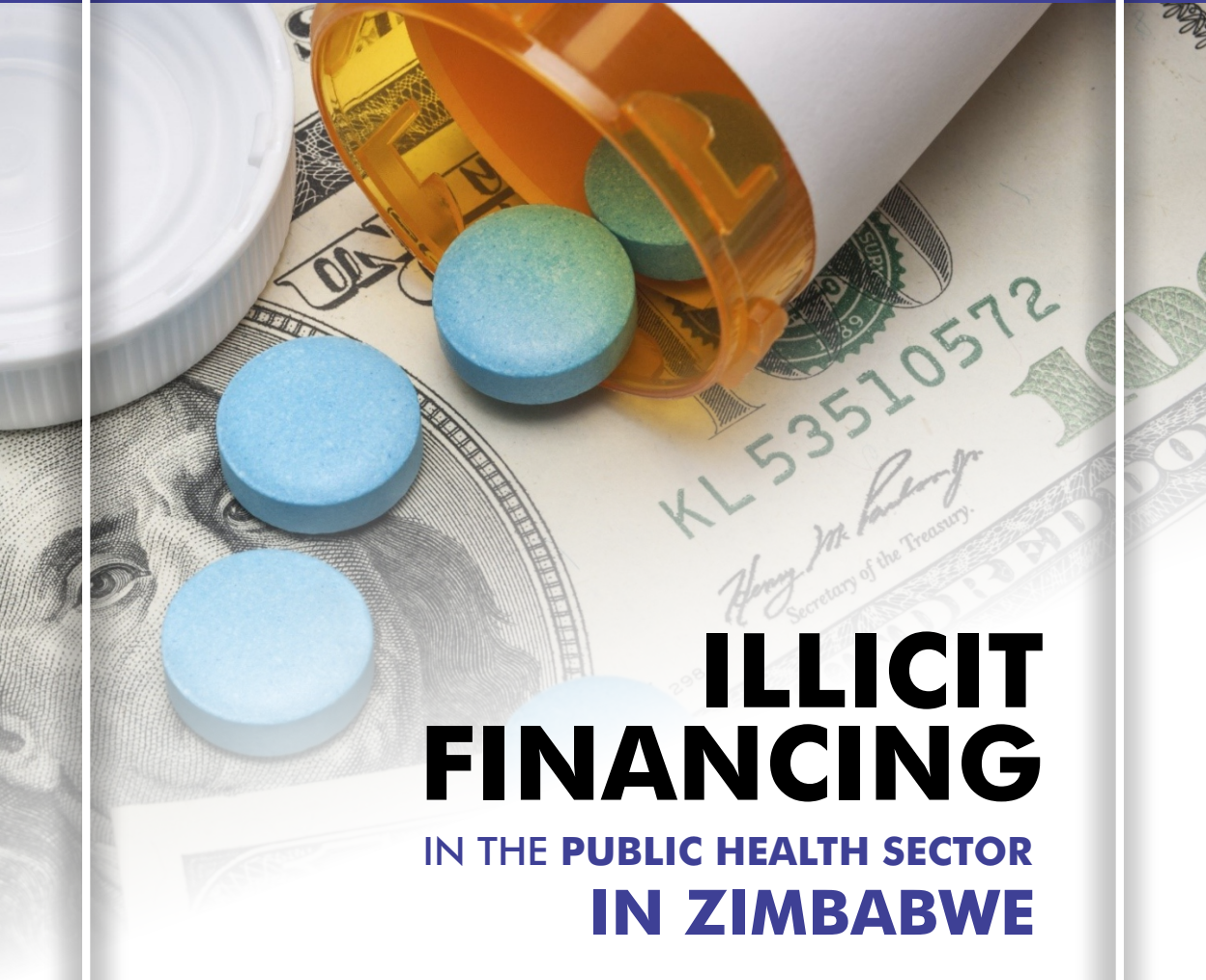




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ILLICIT FINANCING

**IN THE PUBLIC HEALTH SECTOR
IN ZIMBABWE**

About Transparency International Zimbabwe

Transparency International Zimbabwe (TI Z) is a non-profit, non-partisan, systems-oriented local chapter of the international movement against corruption. Its broad mandate is to fight corruption and promote transparency, accountability and integrity at all levels and across all sectors of society. TI Z believes corruption can only be sufficiently tackled by all citizens including people at grass root level.

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
APEA	Applied Political Economy Analysis
ART	Antiretroviral Treatment
AU	African Union
BEAM	Basic Education Assistance Module
BLT	Build Lease And Transfer
COVID-19	Coronavirus Disease 2019
CRF	Consolidated Revenue Fund
GDP	Gross Domestic Product
GOZ	Government Of Zimbabwe
HCC	Health Centre Committee
HIV	Human Immune Virus
HPA	Health Professions Authority
HRH	Human Resources For Health
HSB	Health Service Board
ICDS	Inter-censal Demographic Survey
IMF	International Monetary Fund
IFF	Illicit Financial Flows
INGO	International Non-governmental Organization
MCAZ	Medicines Control Authority Of Zimbabwe
MDGs	Millennium Development Goals
MMR	Maternal Mortality Rate
MOHCC	Ministry Of Health And Child Care
MOPSLSW	Ministry Of Public Service, Labour And Social Welfare
NAC	National Aids Council
NATF	National Aids Trust Found
NatPharm	National Pharmaceutical Company
NCD	Non Communicable Disease
NGO	Non-governmental Organisations
NHS	National Health Strategy
PEPFAR	President's Emergency Plan For Aids Relief
PFM	Public Financial Management
PMD	Provincial Medical Director
PSMAS	Premier Services Medical Aid Society
PPDPA	Public Procurement And Disposal Of Public Assets Act
PPE	Personal Protective Equipment
PPP	Public Private Partnerships
PS	Permanent Secretary
RBF	Result Based Funding
SADC	Southern African Development Committee
SDGs	Sustainable Development Goals
TB	Tuberculosis
UNICEF	United Nations Children Education Fund
VHW	Village Health Worker
WFP	World Food Programme
WHO	World Health Organization
ZIMRA	Zimbabwe Revenue Authority
ZNFPC	Zimbabwe National Family Planning Council
ZPCS	Zimbabwe Prisons And Correctional Service



Illicit financial flows have far reaching ramifications on social, economic and political aspirations for both developed and developing countries. However, the social effects on low income countries are manifold as they struggle to mobilise domestic resources. This has triggered global attention and Zimbabwe is among the most affected by illicit financial flows. The country is estimated to be losing US\$3 billion annually. Illicit financial flows strain the national fiscus, further compromising the provision of public goods and services. Whereas resource leakages are rampant in all sectors of the economy, the impact of illicit financing in the health sector has dire consequences. Apart from being impacted by illicit financing, the health sector is also susceptible to the same. There is indisputable evidence of resource leakages from the health sector itself.

Whilst the concept of illicit financial flows appears to be a preserve of economists, lawyers and accountants, the implications are felt by the millions of vulnerable women, children, youth and people with disabilities who rely mostly on public services. One would argue that the failure of the government of Zimbabwe to provide basic health care such as family planning, reproductive health, and child immunisation to vulnerable and marginalised groups is a violation of the right to health as enshrined in the Constitution of Zimbabwe (No.20) Act 2013.

The disparities between public and private health delivery systems, including the abuse of public resources by senior public

officials and politically exposed persons as they seek medical support from other countries has often been a subject of contestation. However, the COVID-19 pandemic has brought about many lessons which should serve as an impetus for the government of Zimbabwe to curb illicit financing in the health sector as a way of improving the quality of public health care.

The United Nations through the Financing for Development Programme has singled out the scourge of illicit financing as a major hinderance to the achievement of the 2030 Agenda for Sustainable Development. Therefore, in countries where resource leakages are high, achieving all the 17 Sustainable Development Goals becomes elusive. Specifically, for this report, Sustainable Development Goal No. 3 on good health and wellbeing is under threat.

Furthermore, Transparency International Zimbabwe has over the years noted with concern the increasing collusion between private sector players and the public sector as it relates to public procurement and cross border transactions. This is despite robust legal and institutional frameworks governing public procurement and public finance management. In this regard, implementation of key legal and policy frameworks becomes key in curbing illicit financing.

Through this study, Transparency International Zimbabwe aims at not only highlighting the ways in which illicit financing occurs in the health sector. Rather, it is also our hope that this study will increase

discourse on the need to take decisive action against illicit financing. From our perspective, it is evident that the public health sector challenges we are facing as a country can, to a great extent, be attributed to resource leakages rather than the unavailability of resources. Therefore, the long term public health sector development framework should include efforts for curbing illicit financing and strengthening public finance management systems.

Muchaneta Mumbo

Executive Director



Executive Summary

The health of Zimbabwe's young population is a primary determinant of economic wellbeing and poverty reduction in the country.¹ Along with other social sectors such as education, investment in the health sector has been a stated national priority since independence and access to basic healthcare is now enshrined as a constitutional right for all citizens and permanent residents. Despite nearly universal recognition of the critical importance of an effective and equitable healthcare system, the sector faces both longstanding and new challenges that impact the quality of and access to health services and programs. The sector is plagued by chronic underfunding of health priorities, a problem which is exacerbated by the evolving currency crisis.

Many of the challenges facing the health sector are worsened by the misappropriation of public funds for private gain in the form of **illicit finance**. Illicit economic activities contribute to the loss of wealth for the Government of Zimbabwe (GOZ) and citizens, depleting resources that could otherwise be invested in the public health system for healthcare worker salaries, procurement of medical supplies, and the rehabilitation and development of health infrastructure. For a country that needs to grow at an average 7% GDP over the next decade to achieve its sustainable development goal (SDG) targets, including goals focused explicitly on health outcomes, reducing losses from the incidence of illicit finance should be a national imperative. The cost of illicit finance in the health sector is especially stark in the

pandemic.

Zimbabwe's health system is linked to a complex and challenging political and economic context which serves to divert attention away from addressing critical health challenges, limit the availability of financial and material resources, and shape incentives regarding how health sector resources are used. The country is faced with what the WFP Zimbabwe Country Director and Representative, Niels Balzer, has described as "a triple threat of climate induced drought, economic crisis, and the COVID-19 pandemic."²

The study investigated the shape and structure of financial flows within the health sector, with the aim of identifying the risks and vulnerabilities that give rise to illicit finance. The findings help explain **why** illicit finance is an important feature of the health sector, **what** drives these dynamics and presents a basic typology of what types of illicit finance occur within the health sector. The study found eight types of illicit finance in the health sector which fall into four categories. The study focuses on four types which are most prominent – corrupt procurement, petty corruption, smuggling and theft. Smuggling and theft stand out as key illegal activities that give rise to the flow of illicit finance. These illegal activities, like petty corruption, take place in a dispersed manner and take advantage of a myriad of loopholes in legislation, weaknesses in enforcement and economic pressures for the availability of cheap medical supplies.

Illicit finance has an overall negative impact on the health sector which manifests in

1. WHO. 2004. Investing in Health for Economic Development
2. US Embassy in Zimbabwe. 2020, July 6. U.S. contributes \$60.55 million to the WFP to assist Zimbabwe during the lean season

various forms – public funds are wasted, citizens are underserved, public sector workers and donors are demoralized, lives are put at risk, private businesses become unsustainable and the capacity of public institutions is hollowed out. Illicit finance in the health sector is enabled by myriad interests and institutional weaknesses, manifesting in many forms. It therefore requires action on multiple fronts to meaningfully reduce its occurrence. There are a broad set of regional and global experiences that can inform practice within Zimbabwe, and such approaches must be customized to the unique political realities of the local context.



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1. Introduction



The provision of basic healthcare is a lynchpin of socioeconomic development in Zimbabwe. The health of Zimbabwe's young population is a primary determinant of economic wellbeing and poverty reduction in the country.³ The health sector plays a key role in contributing to a productive workforce and ensuring that children are well educated. Along with other social sectors such as education, investment in the health sector has been a stated national priority since independence and access to basic healthcare is now enshrined as a constitutional right for all citizens and permanent residents under Section 76 of the Constitution of Zimbabwe.

Despite nearly universal recognition of the critical importance of an effective and equitable healthcare system, the sector faces both longstanding and new challenges that impact the quality of and access to health services and programs. The sector is plagued by chronic underfunding of health priorities, a problem which is exacerbated by the evolving currency crisis. Strikes and absenteeism by perennially underpaid public health workers remain a feature of the health system and the sector has experienced a steady “brain drain” of healthcare workers in the form of outward migration over the preceding two decades.⁴ Health facilities also face routine shortages of medical supplies, water, and electricity on top of deteriorating infrastructure.⁵ These visible manifestations of a health system under stress are in turn

influenced by less obvious factors, including misaligned incentives and the absence of effective lines of accountability.

Box 1: Understanding Illicit Finance

Many studies of illicit finance focus exclusively on illicit financial flows (IFFs), which refers to the “cross-border movements of money that is earned, transferred or used illegally.” The study team has opted to *employ a broader conceptualization of illicit finance that includes domestic financial flows that are clearly illegal, contrary to formal financial or market norms and against the public interest.* This understanding of illicit finance, therefore, covers a wider range of corrupt financial practices, many of which are closely related to but distinct from classic, cross-border IFFs.

Many of the challenges facing the health sector are worsened by the misappropriation of public funds for private gain in the form of **illicit finance**. Illicit economic activities contribute to the loss of wealth for the Government of Zimbabwe (GOZ) and citizens, depleting resources that could otherwise be invested in the public health system for healthcare worker salaries, procurement of medical supplies, and the rehabilitation and development of health infrastructure. For a country that needs to grow at an average 7% GDP over the next decade to achieve its sustainable development goal (SDG) targets, including goals focused explicitly on health

3. WHO. 2004. Investing in Health for Economic Development

4. Chikanda, Abel (2007) Medical migration from Zimbabwe: magnitude, causes and impact on the poor, Development Southern Africa, 24:1, 47-60

5. Kidia, K. (2018). The future of health in Zimbabwe. Global health action, 11(1), 1496888.

outcomes, reducing losses from the incidence of illicit finance should be a national imperative.

The cost of illicit finance in the health sector is especially stark in the midst of the novel coronavirus (COVID-19) pandemic. The GOZ has moved rapidly to mobilize material and other resources on an emergency basis to address the emerging threat posed by COVID-19. This has included a plan to procure medical supplies and equipment valued at US\$60 million⁶ which has been affected by high-profile cases of abuse of public procurement processes. An effective pandemic response depends on medical personnel being at post, safely equipped personal protective equipment (PPE). It depends on access to testing, treatment, and referrals. Putting these functions into practice require the effective, efficient, and transparent use of health sector resources.

The report begins with an assessment of the context and institutional framework of the health sector. This is followed by a description of the methodology used for the study and the APEA findings. The report is then concluded by an analysis of the key trends of illicit finance in the sector and recommendations for stakeholders to curb illicit finance.

6. Reuters. Zimbabwe health minister arrested over \$60 million COVID-19 equipment contract: media reports. 2020, June 1

2. Methodology

The research study was fundamentally aimed at mapping the various influences and pressures on financial flows within the health sector, with attention to describing the risks that give rise to the incidence of illicit finance.

In examining the health sector, the research team utilized DFID's *Drivers of Change framework*⁷, which supports analysis across three broad categories, “drivers”:

- **Structures:** Long-term contextual factors over which change very little over time, meaning that the factors are little influenced by project interventions and individual actors
- **Institutions:** The formal laws, policies, and informal norms that influence the behaviour and decisions of key actors within a given system
- **Agents:** The institutional and individual actors within the focal system

In opting to utilize the Drivers of Change framework, the research team determined that the analytical lens was largely consistent with the APEA framework, which is built around four domains: **foundational factors, rules of the game, here and now, and dynamics**. Furthermore, the research team focused significantly on understanding the relevance of current events (i.e. the “here and now”), which is reflected less explicitly in the Drivers of Change framework.

The research team used a combination of secondary and primary sources as the basis for the research. A diverse set of secondary material was used as a basis for this study. These included media articles, academic journals, technical reports by Government and multilateral institutions and, laws and policies to records of Parliamentary discourse.

7. DFID. 2014. Smart Guide: Political Economy Analysis.9

3. Background

3.1 Health Sector Challenges

Expanding access to quality healthcare has remained a stated national priority since Zimbabwe's modern founding in 1980. A focus on social development, particularly in the health and education sectors, was central to the social contract established by the GOZ with its citizens. Following independence, the GOZ inherited a health infrastructure that was skewed away from its majority rural, black population. In 1980, for example, there were 74 government district and rural hospitals served by just 16 doctors in the country's rural communities;⁸ by June 2020 there were 106 district and rural hospitals⁹ with each district served by at least two doctors.¹⁰ With the support of international donors, the GOZ achieved important gains in terms of health outcomes for its citizens in the 20 years following independence, including dramatic reductions in infant mortality increases in immunization between the early 1980s and 1989. By the end of the decade, Zimbabwe had achieved the highest rate of contraceptive prevalence in Sub-Saharan Africa at 43%.¹¹

Healthcare remains a fundamental responsibility of the GOZ and right of Zimbabwean citizens, as codified in Section 76 of the national constitution (see Box 2). Embedding the right to healthcare in the constitution has provided a basis for health advocates to push state authorities for improved health services.

However, Zimbabwe's health sector remains challenged on multiple fronts. Health staff in rural communities are increasingly "young and inexperienced," undermining the quality of care in vulnerable communities.¹² Absenteeism remains a chronic issue and there is generally a shortage of motivated and qualified health workers throughout the public healthcare system. Zimbabwe, for example, has significantly fewer doctors per capita compared to neighbors such as Botswana, South Africa, and Zambia

Box 2: Constitution of Zimbabwe, Section 76, Right to Health Care

1. Every citizen and permanent resident of Zimbabwe has the right to have access to basic healthcare services, including reproductive healthcare services.
2. Every person living with a chronic illness has the right to have access to basic healthcare services for the illness.
3. No person may be refused emergency medical treatment in any healthcare institution.
4. The State must take reasonable legislative and other measures within the limits of resources available to it, to achieve the progressive realisation of the rights set out in this section.

8. Bloom G. Two models for change in the health services in Zimbabwe. *Int J Health Serv.* 1985;15(3):451-468.

9. Ray, S. C., & Masuka, N. (2017). Facilitators and barriers to effective primary health care in Zimbabwe. *African journal of primary health care & family medicine*, 9(1)

10. People's COP20. 2019. *Community Priorities – Zimbabwe*

11. Turnwine JK. Zimbabwe's success story in education and health: will it weather economic structural adjustment? *J R Soc Health.* 1992; 112(6):286-290.

12. The Global Fund. 2013. *Audit of Global Fund Grants to the Republic of Zimbabwe*

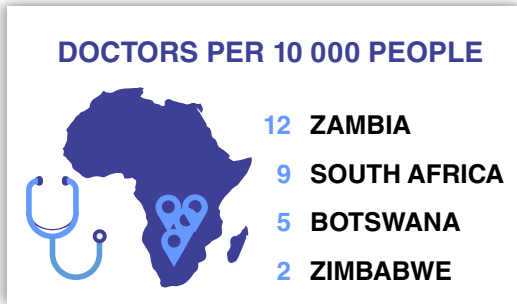


Figure 1: Structure of Public Health System

Zimbabwe's fragile healthcare system is tied to the country's economic implosion during the 2000s, which strained investment in the sector and drove the outward migration of skilled medical personnel at a time of increasing demands due to the HIV/AIDS pandemic¹³. Underfunding within the health sector results from both chronic and acute factors. In 2017, total health expenditure (including private, public, and donor spending) was US\$110 per person, significantly less than its wealthier neighbors, Botswana (US\$386) and South Africa (US\$466)¹⁴. While national investment in the health sector compared more favorably with countries such as Zambia (US\$68), the real value of this spending has depreciated significantly due to inflation. Over the first six months of 2020, the GOZ spent ZW\$164 per citizen in the health sector, equivalent to US\$1.64 at the time of writing. This contributes to an environment in which public health workers are under-paid and health facilities do not acquire enough resources. Academics¹⁵ and the World

Health Organization (WHO) recommend that countries spend at least US\$86 per capita or 5% of gross domestic product (GDP) on health.¹⁶ The African Union countries have pledged to allocate at least 15% of annual budgets to the health sector in what is known as the Abuja Declaration.¹⁷ Zimbabwe has frequently failed to meet these targets in its public expenditure on health.

The lack of effective and efficient investment within the health sector has contributed to Zimbabwe not meeting key health outcomes. Despite making important progress, Zimbabwe fell short of achieving the three health-related **Millennium Development Goals set for the year 2015: MDG 4: Reduced child mortality; MDG 5: Improved maternal health; and MDG 6: Combat HIV/AIDS, Malaria and other diseases.** Examples of lagging indicators include, percentage of children under weight, maternal mortality ratio and deaths due to HIV/AIDS as shown in the table 1 below.

The MDG's have been replaced by the Sustainable Development Goals (SDGs), which continue to serve as a focus of national and international action. SDG 3, **Ensure healthy lives and promote well-being for all at all ages**, directly focuses on health while SDG 5, **Achieve gender equality and empower all women and girls**, highlights the need to address specific health-related challenges that affect women and girls.

Table 1: Selected MDG Indicators and Results

Indicator	Baseline	Target	Archivement
Percentage of children underweight	11%	8,8%	11%
Material mortality ratio deaths per 100 00 live births	1 069	458	562
Total AIDS deaths	122 282	22 109	38 616

13. World Bank. 2015. Health Public Expenditure Review for Zimbabwe
14. Ibid.

15. WHO. 2002. How Much Should Countries Spend on Health?
16. UNICEF. 2020. Zimbabwe Health Budget Brief
17. WHO. 2011. The Abuja Declaration: Ten Years On

3.2 Context

Zimbabwe's health system is linked to a complex and challenging political and economic context which serves to divert attention away from addressing critical health challenges, limit the availability of financial and material resources, and shape incentives regarding how health sector resources are used. The country is faced with what the World Food Program (WFP) Zimbabwe Country Director and Representative, Niels Balzer, has described as **“a triple threat of climate induced drought, economic crisis, and the COVID-19 pandemic.”**¹⁸ Each of these challenges is also compounded by political fracturing and repression.

Zimbabwe is in its second year of a deep recession, which comes at a time when the country has yet to recover from the recession of the 2000s. Zimbabwe's economy contracted by 8.3% in 2019 due to drought and self-confessed 'missteps'¹⁹ by the GOZ in the implementation of austerity policies. The COVID-19 pandemic is further deepening the recession. According to the latest IMF forecasts from April 2020, GDP growth is expected to remain negative in 2020 at -7.4% due largely to COVID-19. An El-Nino influenced drought reduced agricultural output, reduced water availability (especially in urban areas) and depressed hydro-electricity production. These dire economic conditions have in turn affected the manufacturing sector, which is not only reliant on electricity and water but also on agriculture for 60% of its inputs. Poorly

formulated and unstable monetary policies led to inflation, measured at 838% in July 2020,²¹ which eroded savings and incomes thereby consigning many Zimbabweans to poverty. The overall percentage of extremely poor Zimbabweans increased from 27% to 37% between 2017 and 2019.²² It is expected to increase further in 2020.

As of 29 January 2021, Zimbabwe had officially recorded 32 952 cases and 1178 deaths due to COVID-19,²³ a count that understates the real spread of the disease due to under-testing of the population and the failure to account for the large number of asymptomatic cases. The pandemic has placed additional burden on Zimbabwe's already fragile health system. The pandemic hit when nurses were already on strike, the public health sector had a small number of functional ventilators and inadequate PPE for health workers, and public funds for the health sector were dwindling due to inflation.

Deteriorating economic conditions have triggered public discontent, which is manifested in a growing protest movement which has been met by state repression. Evolving protest movements have been active on social media and have brought human rights violations to the attention of the world. While civil society has focused broadly on issues of public corruption, there has been limited focus on the issue of illicit finance specifically, including in the health sector.

18. US Embassy in Zimbabwe. 2020, July 6. U.S. contributes \$60.55 million to the WFP to assist Zimbabwe during the lean season

19. IMF. 2020. 2019 Article IV Consultation—Press Release; Staff Report; And Statement by the Executive Director for Zimbabwe

20. Mushava, E. We made policy missteps: Mthuli. May 1, 2020. Newsday

21. RBZ CPI statistics

22. The World Bank defines “extreme poverty” as living on less than \$1.90 per person per day.

23. MOHCC www.mohcc.gov.zw accessed on 29 January 2021

3.3 Health sector policies & institutions

Public health policy is currently guided by multiple key legislative acts, strategies, and policy frameworks, principally including the Public Health Act (2018), the National Health Strategy (NHS) for 2016-2020, and the Health Financing Policy (2017-27). The NHS is organized around the themes of equity and quality, with the aim of *“leaving no one behind”* in terms of access to critical health programs and services. Equity and access is similarly a focus of the Public Health Act, Health Financing Policy, as well as past sectoral strategies. The MOHCC administers at least 20 Acts which cover a wide breadth of policy issues including food standards, abortion rights, drugs and medicines, health professions councils and air pollution.

The public health system is the largest provider of health-care services.²⁴ It consists of four-tiers from the most basic service providers at community level to central hospitals that offer specialist care for the most complex health conditions as depicted in Figure 1.²⁵ Village Health Workers (VHWs) are trained by the MOHCC to provide health education, to assist in the promotion of healthy life styles and in the prevention of communicable and non-communicable diseases.²⁶ Some donor agencies directly support VHWs financially.

While most health facilities are managed by MOHCC, a few others fall under the management of the Ministries of Education,

Defense, Home Affairs and the Zimbabwe Prisons and Correctional Services (ZPCS).²⁷ MOHCC is headed by a Minister, Deputy Minister and a Permanent Secretary (PS). The PS oversees the Chief Executive Officers (CEOs) of the six Central Hospitals, the Chief Directors of 9 Departments and the Provincial Medical Directors (PMDs) who head the 8 tertiary facilities.²⁸

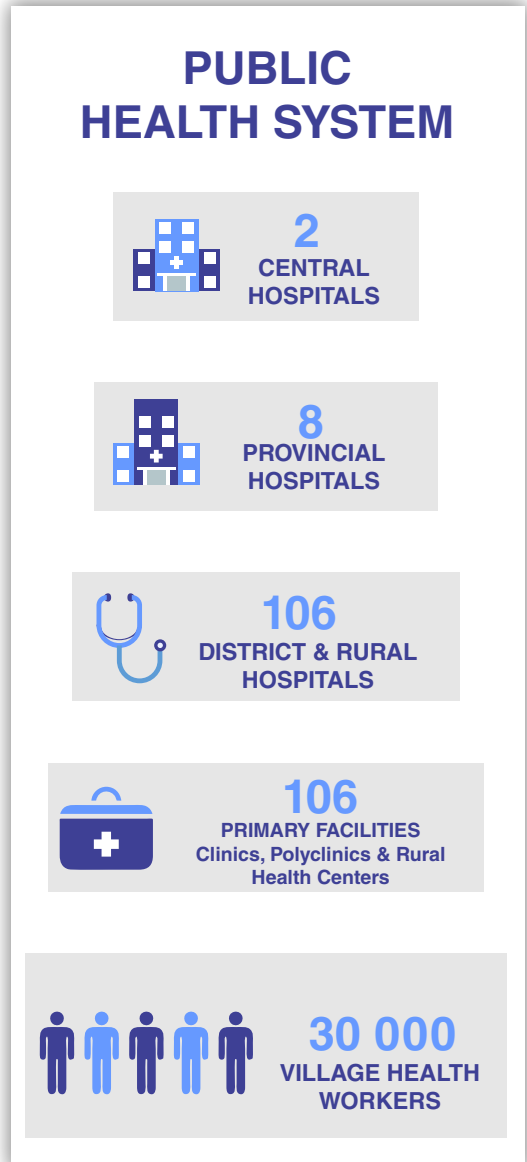


Figure 1: Structure of Public Health System

24. MoHCC. (2013). "The National Health Information Strategy 2009-2013 Equity and Quality in Health: A People's Right", available at: <https://apps.who.int/medicinedocs/en/d/Js17996n/> (Accessed 8 October 2018).
 25. MOHCC. 2015. Zimbabwe Services Availability and Readiness Survey
 26. Parliament of Zimbabwe.2017, May 17. Hansard
 27. MOHCC. 2012. Zimbabwe's E-Health Strategy 2012-2017
 28. PMDs oversee the secondary and primary health facilities in their provinces

Box 3: Institutions overseen by MOHCC

The MOHCC oversees a range of institutions responsible for specific facets of public health policy and administration. Notable institutions include:

- Medicines Control Authority of Zimbabwe (MCAZ): Enforces standards for production, importation and use of medicines and medical devices to ensure safety, effectiveness and quality.
- National Pharmaceutical Company (NatPharm): Procures, stores and distributes medicines and medical equipment for public health institutions, including those managed by local authorities. NatPharm also procures, stores and disburses medicines and medical equipment on behalf of the National Aids Council (NAC)²⁹, the Global Fund, UNDP, UNICEF, USAID, and WHO.³⁰
- National Aids Council (NAC): Disburses the AIDS levy and reports quarterly to MOHCC, MOFED and to Parliament. NAC also procures HIV/AIDS and cancer medication.³¹
- Zimbabwe National Family Planning Council (ZNFPC): Provides family planning services, HIV and sexually transmitted infection (STI) testing and counselling, including cervical cancer screening.
- Health Professions Authority of Zimbabwe (HPA): Coordinates and regulates all health professionals, health professions councils, and health care institutions.

The financing of the public health system is coordinated by the Ministry of Finance and

Economic Development (MOFED). A third (35%) of all expenditure on health in Zimbabwe is made by the GOZ – 22% is directly spent on the public health system and 13% on health insurance for civil servants through the privately-run public medical aid scheme, Premier Services Medical Aid Society (PSMAS).³² Most of the public spending goes to the wages of public medical staff (64%)³³ and to the main public hospitals (5% to the six Central hospitals).³⁴ This leaves very little in the way of fiscal resources for the rehabilitation of infrastructure within primary health facilities and provincial, district and rural hospitals. Not only are budget allocations not enough, but actual disbursements are often less than the budget allocations and payments are unpredictable, making planning difficult. Furthermore, spending is often inefficient and conducted in ways that contravene public financial management (PFM) legislation.³⁵

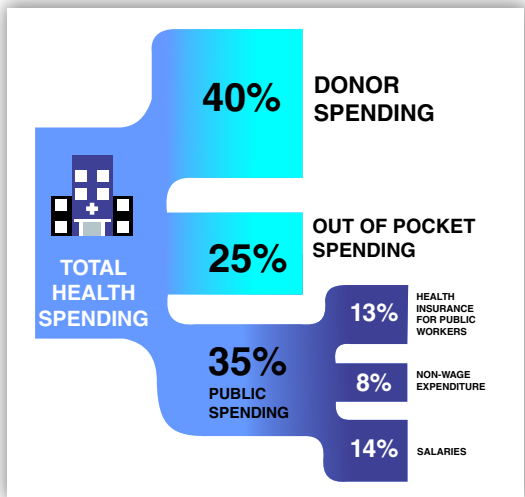


Figure 2: Financing of Public Health System

29. NAC pays the NatPharm 2.5% of the value of NAC's medicals that NatPharm stores and distributes
 30. Parliament of Zimbabwe.2017, May 17. Hansard
 31. Parliament of Zimbabwe.2017, May 17. Hansard
 32. World Bank. 2015. Health Public Expenditure Review for Zimbabwe
 33. MOHCC. 2019. Resource Mapping 2019 Report
 34. Ibid.
 35. ZIMCODD. (2016). "Research Findings Report on Social and Economic Impacts of Public/Private Partnership Agreements to the Realization of the Right to Health: The case of Chitungwiza Central Hospital", available at <http://www.zimcodd.org/sites/default/files/research/> (Accessed 8 October 2018).

With Parliamentary approval, MOFED allocates public resources from the Consolidate Revenue Fund (CRF) to the health sector and collects and disburses levies and taxes that are earmarked for health financing. This includes the ***AIDS Levy***, which is charged on all employees and the ***Health Airtime Levy***, which is charged for every purchase of airtime for mobile telecommunications. The public sector also generates user fees to subsidize the cost of key health services. Public health facilities charge fees for health services and hospitals and clinics can retain the revenue and use it at the facility level. **40% of the financial flows in the health sector come directly from citizen's pockets, representing the largest source of health financing in Zimbabwe.** This is significantly higher than in neighboring countries such as Zambia, where citizens account for 28% health spending versus 48% from public coffers.³⁶ In Zimbabwe, private spending goes to health services offered by both public and private health service providers and includes expenses directly paid by citizens and payments covered through health insurance.³⁷ The Office of the Auditor General audits the finances of all state institutions in the health sector.

While the public health system represents the largest source of health services in the Zimbabwe, there remains an important role for the private sector as a provider of services to health seekers, as well as to the public system itself. The private health system includes 94 primary health facilities (69 private clinics and 25 mission clinics), and 32 private hospitals which vary from

36. ZIMCODD. (2016), "Research Findings Report on Social and Economic Impacts of Public Private Partnership Agreements to the Realization of the Right to Health: The case of Chitungwiza Central Hospital", available at <http://www.zimcodd.org/sites/default/files/research/> (Accessed 8 October 2018).
 37. USAID. 2016. Zambia Health Financing Profile.
 38. Ibid.
 39. World Bank. 2015. Health Public Expenditure Review for Zimbabwe
 40. Dube, Z.L. and Kunaka, P. (2019), "Emergent views on public private partnerships in public hospitals in Zimbabwe", International Journal of Development and Sustainability, Vol. 8 No. 6, pp. 357-366

Box 4: The AIDS Levy

Through the Zimbabwe Revenue Authority (ZIMRA), the GOZ collects an AIDS Levy from all workers in Zimbabwe and transfers it monthly to the MOFED-managed National AIDS Trust Fund (NATF). The MOHCC approves the annual work plan and budget for the AIDS Levy, implements programs funded by the Levy, and oversees activities of the National AIDS Council (NAC). Key programs funded through the Levy include procurement of anti-retroviral drugs and information campaigns. The Ministry of Public Service, Labor and Social Welfare (MOPSLSW) receives some funding from the AIDS Levy which it uses for the Basic Education Assistance Module (BEAM) which provides tuition fees for orphans and vulnerable children.³⁸

secondary to quaternary level.³⁹ The GOZ has piloted ***public-private partnerships (PPPs)*** in the health sector at two Central Hospitals. In 2014, one Central Hospital entered into an abortive Build-Lease and Transfer (BLT) arrangement with a laundry firm whereby the firm was slated to refurbish the hospital's laundry department and then operate it under lease for five years. The plan was for the hospital to pay the laundry firm for the refurbishment over this five-year period.⁴⁰ This paved the way for Chitungwiza Central Hospital to enter into PPPs in five areas: laboratory, radiology, catering services, mortuary and the pharmaceuticals department.⁴¹ PPPs have received mixed reviews. They have been reported to provide more reliable service than traditional public hospital

41. Nleya, F. Chitungwiza Hospital strategic partnerships bear fruit. 2014, July 20. The Standard

42. Dube, Z.L. and Kunaka, P. (2019), "Emergent views on public private partnerships in public hospitals in Zimbabwe", International Journal of Development and Sustainability, Vol. 8 No. 6, pp. 357-366

departments, but their governance has been riddled by lack of accountability, clear responsibilities and transparency.⁴² While there have been fewer and smaller PPPs in the health sector compared to other sectors such as the transport sector, PPPs are subject to collusive arrangements between public and private actors.

40% of health spending comes from external funding from donors.⁴³ Key donors in the health sector include USAID, FCDO (formerly DFID), UNICEF, UNFPA, World Bank, UNDP and UNAIDS. Donor funding goes to procurement of medical supplies and strengthening of the capacity of public and non-profit institutions. Due to the majority of public funding going to funding human resources for health (HRH), donor funding accounts for the majority of health expenditure that goes to procurement of medical supplies. For example, procurement for HIV/AIDS medication (ARVs) and HIV-testing supplies in 2018 cost US\$152 million, of which 86% came from external funding (President's Emergency Plan for AIDS Relief (PEPFAR) and Global Fund) and 14% came from GOZ.⁴⁴ The former Minister of Health noted that this equates to Global Fund taking care of 710,000 patients, PEPFAR, 193,000 and GOZ, 113,000.⁴⁵

USAID provides funding for Zimbabwe's health sector through the PEPFAR (US\$145 million in 2018), the Maternal and Child Health (MCH) program (US\$2 million), the TB program (US\$4 million) and the

Malaria program (US\$14 million). The EU, Sweden, FCDO, Ireland and the Global Vaccine Alliance (GAVI) provide funding through the Health Development Fund (HDF), a multi-donor fund with a focus on reproductive, maternal, child and adolescent health (RMNCH-A). HDF's total budget over 5 years (2016-2020) is approximately US\$680 million. It is managed by UNFPA and UNICEF and partly co-funded by GOZ which has used HDF's systems to procure medical supplies.⁴⁶ The World Bank and the HDF provide funding through the Results Based Financing (RBF) programme to which GOZ commits to match donor funding provided. The World Bank recently committed US\$55 million to the RBF which focuses on RMNCH-A and the COVID-19 response at primary health care facilities which receive the least funding from public funding – it currently covers 18 districts but plans are in place to expand it to all 60 rural districts.⁴⁷ The other 42 districts are currently funded through the HDF.

An efficient and effective public health system requires the adequate and timely supply of drugs, equipment, PPE, chemicals and other materials. These medical supplies are not typically produced by the state and instead must be bought from manufacturers or suppliers. In procuring these supplies, Zimbabwe's public health sector utilizes funds from the three sources: public funds, user fees and donor funds. While there is a common public procurement policy framework, there are differences to the public

43. World Bank. 2020, June 3. Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS). Available at: <https://www.worldbank.org/en/projects-operations/environmental-and-social-policies>

44. US. State Department. 2019, April 5. ZIMBABWE Country Operational Plan 2019 Strategic Direction Summary

45. Langa, V & Gonye, V. We have enough HIV drugs: Moyo. 2019, June 11. Newsday

46. Reliefweb. 2018, January 6. Ministry of Health releases US\$ 7.6m to the Health Development Fund for the purchase of essential medicines and health equipment⁴⁷. World Bank. 2020, June 3. Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS). Available at: <https://www.worldbank.org/en/projects-operations/environmental-and-social-policies>

47. World Bank. 2020, June 3. Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS). Available at: <https://www.worldbank.org/en/projects-operations/environmental-and-social-policies>

procurement policy framework, there are differences to the public procurement processes for each of these types of funds.

GOZ spent ZW\$234 million on medical supplies and services in 2019, equivalent to US\$10.6 million as of December 2019.⁴⁸ This money is disbursed by the MOFED to suppliers and procurement is conducted by MOHCC and other MDAs in the health sector such as NAC. The process is guided by a legal and policy framework that consists of the Public Procurement and Disposal of Public Assets Act (PPDPA), subsidiary regulations and guidance documents. The Permanent Secretary (PS) of MOHCC is ultimately responsible for all procurement while PRAZ provides oversight. The MOHCC's Department for Procurement Services supports the PS in administration of procurement in the public health sector. Local Authorities manage some of the public health facilities and they procure medical supplies using the same legislation and through their budget processes.⁴⁹ Local authorities use the user fees they collect from patients for health services while sixteen urban local authorities receive funds from the MOHCC mainly for subsidizing health services for children under five and the elderly (persons over 65) and, maternal health services. Like the MOHCC, local authorities conduct procurement in line with the PPDPA and under PRAZ's oversight. In addition to providing health services, local authorities also conduct health inspections of all food premises and shop licensing of health-related companies.

Due their different funding models, there are various procurement methods that range from donors procuring medical supplies using their own procurement processes to donors providing funds directly to the State to manage procurement using government systems. Some donor funding is expended through INGOs and NGOs while some is expended by GOZ. Most procured medicines are however distributed using NatPharm's distribution system and through public health facilities. The RBF has a unique procurement process in that spending is managed at the primary facility level. Facility workers indicate what they want to procure and the RBF budget line they will charge. Three quotations are sought for by the facility workers. Then a Health Centre Committee (HCC) which consists of facility workers and community members, and chaired by a member of the community, evaluates the quotations and selects a supplier. Two members of the HCC - one facility worker and one community member then go together to make the purchase.



48. MOFED Fiscal Data

49. Gwati, G. 2014. Desk Review of purchasing arrangements for public health services in Zimbabwe

3.4 Human Resources for Health

The Human Resources for Health (HRH) consist of “all people engaged in actions whose primary intent is to enhance health”.⁵⁰ In Zimbabwe, HRH includes clinical staff such as physicians, nurses, pharmacists and dentists; management and support staff such as managers, ambulance drivers and accountants; and formally untrained health workers, the informal sector health workers such as practitioners of traditional medicine and health volunteers, including family care givers.⁵¹ Health systems function best when they have the right number and mix of human resources in well-equipped facilities with the right competencies and level of motivation.⁵²

HRH in Zimbabwe is characterized by a substantial shortage of skilled and experienced clinical staff. While the country has training institutions, the sub-par working conditions that are characterized by low incomes, high staff turnover, lack of personal protective equipment, shortages of medical supplies and a regular moratoriums on hiring have triggered a mass exodus of clinical staff from the country to neighbouring countries and overseas to countries such as the UK, Australia and Canada – only 27% of the nurses trained in Zimbabwe between 2010-2019 were recruited by MOHCC.⁵³ In addition, the public sector also loses its skilled and experienced staff to the local private and non-profit health institutions. Rural public institutions are the worst affected as GOZ finds it difficult to fill posts in rural areas⁵⁴ and key clinical staff such as

doctors, pharmacists, radiographers and anaesthetists are concentrated at the six Central Hospitals.⁵⁵ The public sector thus has a large number of vacancies in almost every clinical category which GOZ has decided to not fill in the short-term as it struggles to fund the sizeable public wage bill. As of 2019, 10% of the MOHCC's 35,583 posts were vacant.⁵⁶ Clinical and specialist positions such as specialist physicians, analyst chemist and medical laboratory scientists have the most acute shortages.⁵⁷



50. World Health Organization, 2009. Toolkit on monitoring health systems strengthening

51. Health Service Board. 2018. Human Resource for Health Policy Zimbabwe

52. USAID, n.d. Human Resource for Health Indicators

53. People's COP20. 2019. Community Priorities – Zimbabwe

54. Chinwa, Y. C. P. M. M. a.-G., 2016. Deployment for Human Resources for Health in Zimbabwe: Synthesis report ReBUILD RPC working paper

55. People's COP20. 2019. Community Priorities – Zimbabwe

56. World Bank. 2020, June 3. Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS). Available at: <https://www.worldbank.org/en/projects-operations/environmental-and-social-policies>

57. Health Service Board. 2018. Human Resource for Health Policy Zimbabwe

Recent salary increments have fallen short of the inflation rate and salaries are currently much lower than they were before 2018. Some donors finance HRH in the public system. For example, USAID's PEPFAR program supports financing supports over 14,000 health care workers in districts that it prioritizes.

A National HRH Policy was introduced in 2018 with the objective “to ensure the availability of the right number of health workers who have the right knowledge, skills, attitudes, qualifications; are performing the right tasks in the right place at the right time; and are well-managed, remunerated and motivated.”⁵⁸ Its development was overseen by an HRH Taskforce comprising GOZ and development agencies and consultations

included various professional associations, City Health Departments, training institutions, faith-based organisations and the Association of Health Funders of Zimbabwe (AHFoZ). The Health Services Board (HSB) and MOHCC play a key role in the implementation of the National HRH Policy with support from the HRH Taskforce. The key interventions of the National HRH Policy are development of a Human Resources for Health Information System (HRHIS), improvement of training of HRH, improve conditions of work and engage donors to finance HRH. Over the first two years of its implementation, the Policy's objectives have not been met – incomes are lower today than they were in 2018 while nurses and doctors have spent a significant portion of the past two years on strike.



58. Ibid.

4. Findings

The study investigated the shape and structure of financial flows within the health sector, with the aim of identifying the risks and vulnerabilities that give rise to illicit finance. The findings help explain **why** illicit finance is an important feature of the health sector, what drives these dynamics and presents a basic typology of **what** types of illicit finance occur within the transport sector.

4.1 Typology of Illicit Financing in the Health Sector

The study found eight types of illicit finance in the health sector which fall into four categories as shown in the graphic below. The study focuses on four types which are most prominent – corrupt procurement, petty corruption, smuggling and theft. Smuggling and theft stand out as key illegal activities that give rise to the flow of illicit finance. These illegal activities, like petty corruption, take place in a dispersed manner and take advantage of a myriad of loopholes in legislation, weaknesses in enforcement and economic pressures for the availability of cheap medical supplies.

Table 2: Typology of illicit financing in the Health Sector

Category I. Trade Mis invoicing	Category II. Tax Abuse	Category III. Abuse of Office	Category IV. Illegal Activities
1. Over pricing imports	1. Tax avoidance 2. Tax Evasion	1. Collusion between public officials and the private sector 2. Petty Corruption 3. Corrupt procurement	1. Smuggling 2. Theft

Trade Misinvoicing

Trade misinvoicing, which is the intentional misstating of the true value or volume of traded goods, is the largest component of IFFs worldwide⁵⁹ and the primary vehicle for shifting illicit funds between developing and advanced countries, accounting for approximately 19–24% of developing country trade in 2006–2015.⁶⁰ In the context of Zimbabwe, trade misinvoicing occurs primarily as a strategy for evading capital controls and, to a lesser extent, to avoid taxes. Trade misinvoicing manifests in the health sector as **overpricing of imports**.

Tax abuse

Tax evasion and avoidance are illicit finance-related behaviour by economic actors across the economy, including in the health sector. Although treated as its own type of illicit finance, tax evasion helps explain other categories and types, including trade misinvoicing, corrupt payments to public officials, various types of collusion between public and private sector actors, and the smuggling of medical supplies into the country. Tax evasion is enabled by multiple factors: the Zimbabwe Revenue Authority (ZIMRA) lacks the administrative capacity to effectively monitor and track imports of medical supplies and operations of the dispersed retail pharmacy sector. Weaknesses in financial disclosure requirements mean that larger companies are able to misrepresent their finances with minimal fear of audits.

59. Global Financial Integrity (GFI). 2020. GF Trade [webpage]. Retrieved from <https://gointegrity.org/gftrade/>.

60. GFI. 2019. Executive Summary. In Illicit Financial Flows to and from 148 Developing Countries: 2006-2015. Retrieved from <https://secureservercdn.net/45.40.149.159/34n.8bd.myftpupload.com/wp-content/uploads/2019/01/GFI-IFF-Update-Report-2019-Executive-Summary.pdf?time=1574338601>.

Abuse of power

Abuse of power is at the centre of most illicit finance, serving both to enable the initial act of corruption and remove the threat of punishment. Diverse actors are attracted to the economic rents generated by strong state involvement in the health sector. Corrupt public procurement is a significant issue in the public health system while collusion and petty corruption also take place to a lesser degree. Abuse of power is covered in more detail in the Findings chapter.

Illegal activities

As in other sectors, the health sector is marked by *theft, smuggling and other criminal activity*. Illegal activities such as theft of medical supplies and smuggling of medical supplies across borders are common and covered in more detail in this study.

4.2 Corrupt Public Procurement

Corruption in public procurement occurs when civil servants or other officials contravene established procurement regulations to direct government tenders toward favored suppliers or to facilitate kickbacks to themselves.⁶¹ Past research has found that corrupt procurement is a dominant form of illicit finance across multiple sectors, including energy and agriculture. The 2019 National Budget shows that GOZ spent US\$ 104 million on public procurement in the health sector in 2018 – 22% of the total budget allocation for the MOHCC.⁶²

While the majority of medical supplies are currently procured by donors, the research

team made a deliberate decision to focus on corruption in the public procurement system i.e. procurement that uses public funds and user fees. The rationale is that both public funds and a large portion of the donor funded procurement utilizes some or all of the public health system's supply chain for medical supplies. Notwithstanding the current low public resources available for procurement, public procurement will remain very important because it is the most permanent of all sources of funding for public procurement and if reformed well, has the potential to deliver lasting benefits for the citizens of Zimbabwe.

Corrupt procurement has far-reaching results for citizens, particularly for the most impoverished Zimbabweans, as it depletes the public healthcare system of critical resources that would otherwise be put toward productive uses. Health system providers, users, and observers describe pronounced material and equipment shortages that have a direct or indirect impact on the quality of care, as well as utilization of the system. For example, one of the most worrying health indicators in Zimbabwe is its high maternal mortality rate, which at 651 maternal deaths per 100,000 live births is one of the highest in the world. It includes deaths from abortions which are illegal in Zimbabwe and usually done clandestinely. A study found that more than half of the public health facilities reported shortages of misoprostol – an essential medicine for postabortion care while “half of the facilities designated under national guidelines to provide manual vacuum aspiration did not have the equipment to do so.”⁶³

61. Soreide, T. 2002. Corruption in public procurement: Causes, consequences and cures

62. MOFED. 2018. 2019 National Budget – Blue Book

63. Guttmacher Institute. 2018. Induced Abortion and Post abortion Care in Zimbabwe

I guidelines to provide manual vacuum aspiration did not have the equipment to do so”.

Box 5: How corrupt procurement is experienced within the health system

Respondents described multifaceted impacts of corrupt public procurement within the health system. Some of the impacts are obvious and direct, such as paying more for essential supplies and medicines. Others are indirect and less obvious, such as the corrosive effect of material shortages on health personnel moral and the utilization of healthcare services.

- **Inefficient expenditure:** Respondents described significant inefficiencies in procurement process and the consistent overpricing of goods and services. For example, a MOHCC audit of Chivhu General Hospital found that some prices of procured goods and services were inflated by as much as 700%.⁶⁴
- **Shortages of essential supplies and medicines:** This has a demoralizing effect on the health workers. Shortages have dire consequences - 44% of rural households do not have insecticide-treated mosquito nets (which are distributed for free by MOHCC) and Zimbabwe records over a quarter of a million cases of malaria a year leading to hundreds of deaths.⁶⁵
- **Procurement of the wrong goods and services:** While facing shortages in essential services, health facilities often receive goods and services that are not a priority. In many cases equipment and supplies become obsolete due to the lack of use. A traditional chief

complained in Parliament about the MOHCC purchasing x-ray and laundry machines for a public hospital which were not installed for years when the hospital was under-staffed, while simultaneously experiencing perennial shortages of drugs.⁶⁶

- **Acquisition of sub-standard goods and services:** The quality of goods and services that are procured is frequently compromised as the *best briber* often receives a particular contract.⁶⁷ This may lead to the delivery of equipment and supplies that are unusable, such as expired drugs. The study found that anti-retroviral drugs are regularly delivered to health facilities close to their expiry dates and that contracted entities get away with delivering sub-standard foods because they bribe the public officials who are supposed to conduct quality control.
- **Payment for goods and services not delivered:** The study found cases whereby GOZ paid for goods and services that are not provided. The Office of the Auditor General (OAG) found a CD4 count machine which had not been functional at Gokwe South district hospital for over two years yet the MOHCC had paperwork that showed it had paid for the maintenance works for the machine and the work had been done six months before the audit finding.⁶⁸ It has been alleged that in many instances the companies that received payments and do not deliver goods and services are owned by the public officials who participate in the awarding of the contracts and are supposed to follow-up on the delivery – a clear case of conflict of interest.

65. US Embassy in Zimbabwe. 2019, April 25. The United States celebrates decline in malaria cases and deaths in Zimbabwe on World Malaria Day 66. Parliament of Zimbabwe.2017, May 17. Hansard

66. Parliament of Zimbabwe.2017, May 17. Hansard

67. Chimberengwa, P. 2015. Procurement Processes at Gwanda Provincial Hospital, Matabeleland South Province, Zimbabwe, 2012.

68. The Global Fund. 2013. Audit of Global Fund Grants to the Republic of Zimbabwe

64. Gumbo, L. US\$2,5m health scam exposed. 2013, December 23. The Herald

Politically exposed persons (PEPs) benefit from the current procurement system:

Respondents and the public record make clear that the politically connected exert significant influence over public procurement processes to their own benefit.

Public procurement abuse thrives due to a combination of factors. **Weak institutions** limit enforcement of the rules governing public tendering processes. Complex systems of **political patronage** incentivize abuse of public procurement and simultaneously shield the politically connected from sanctions. Furthermore, **unstable macroeconomic conditions** further encourage public and private agents to take advantage of tendering processes. These and other factors are described below.

Weak Institutions

The weakness of institutions within the public health system is characterized by under-staffing, under-funding and manifests itself in the “lack of ownership of key processes”⁶⁹, weak oversight over public procurement, poor record-keeping⁷⁰ and inadequate monitoring of the pharmaceuticals industry by MCAZ. There also exists an overall **lack of transparency** in MOHCC’s procurement practices, as evidenced by failure by MOHCC and PRAZ to publish procurement notices and awards on the PRAZ website as required by the law.

There is also inadequate involvement of front-line staff in procurement decisions.⁷¹ For example, a doctor who formerly worked at a Central Hospital noted how the hospital’s procurement department which

is comprised of non-medical staff procured medical supplies with no involvement of senior doctors or nurses in the prioritization of supplies or the evaluation of bids. Furthermore, there remains a lack of Parliamentary oversight of key public expenditure in the health sector. In particular, the GOZ pays for some public procurement using retention and statutory funds (RSFs), user fees collected at health facilities, and the AIDS Levy and Airtime Health Levy which is not subject to Parliamentary oversight.

Political Patronage

The weakness of governance institutions is partly the result of patronage politics, which permeates the health sector (as all sectors) and further incentivizes misuse of public procurement. Patronage is characterized by the maintenance of relationships between public officials with appointing power (patrons) and the appointees (clients), that are based on the exchange of goods, influence, and other favors as a means of maintaining and advancing the status of particular political actors. These patron-client relationships have the effect of blurring the boundaries between the public and private spheres, while the capture and distribution of public resources to support these relationships is facilitated by long-standing efforts to weaken formal institutions and state capacity. Clients manage public funds and carry out the day-to-day public procurement in the public health sector. They are therefore able to give state contracts to their political patrons and their private sector associates. In return they are granted **impunity from accountability**.

69. The Global Fund. 2013. Audit of Global Fund Grants to the Republic of Zimbabwe 70. Ibid.

71. Chimberengwa, P. 2015. Procurement Processes at Gwanda Provincial Hospital, Matabeleland South Province, Zimbabwe, 2012; a Descriptive Cross Sectional Study. Austin Journal of Public Health and Epidemiology 2(1)

Unstable Macroeconomic Environment

The macro-economic instability in Zimbabwe has led to severe inflation and shortages of foreign currency. *Inflation has eroded the incomes of civil servants in the health sector and this has provided incentive to engage in petty corruption as a means of supplementing their meagre earnings.* The RBZ has listed the importation of drugs as one of the priority areas for allocation of scarce foreign currency and imports of medical supplies are one of the country's top imports, which makes the sector a target for rent-seekers looking to acquire 'cheap' foreign currency from the RBZ. While in some cases, rent-seekers who receive foreign currency remit the funds out of the country and do not purchase medical supplies, more often importers engage in trade misinvoicing to keep a share of the foreign currency. Public officials are also motivated to avoid procuring goods and services on the local market as these are paid for in local currency, whereas imported products are paid for in foreign currency from which they can get a kick-back.

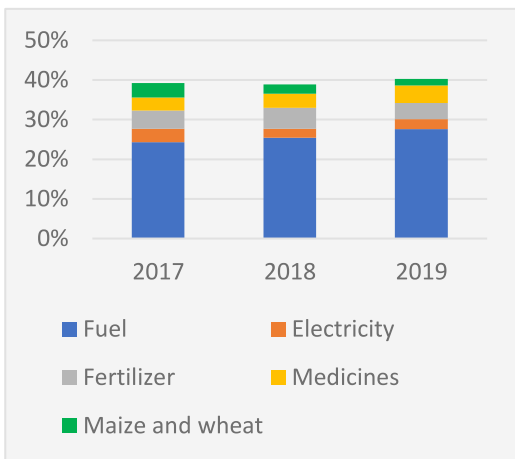


Figure 3: Zimbabwe's top imports

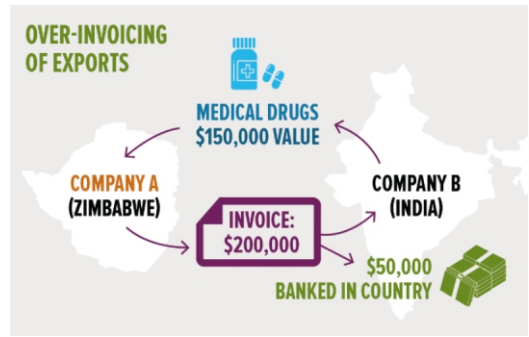


Figure 4: Trade misinvoicing in the import of drugs

The *high credit risk* of MOFED and RBZ disincentivizes large, reputable and successful businesses from bidding for state contracts to supply drugs leaving space for smaller and less reputable, risk-taking firms who are oftentimes willing and able to collude with politicians as a means to mitigate their risk and inflate their profits. In July 2020, Parliamentarians criticized PRAZ for registering foreign middlemen to supply drugs.⁷² A key red flag is the existence of companies that do not sell supplies to the private health system but only take part in public tenders where they charge ridiculous prices.

Other enablers of corrupt procurement

Corrupt procurement takes place through various means and is driven by a range of other factors. Officials conducting procurements routinely ignore or fail to conduct due diligence on the past performance of a bidder. Furthermore, it is common for those officials to solicit kickbacks, illegally limit the call for bids, and design tenders and provide confidential information to favour the bribing company. In the case of Young Health Care Limited, ZACC found that their bid was exactly the amount that the MOHCC had in its account at that time which led ZACC to believe that the company had inside information.⁷³

72. Langa, V. PRAZ grilled over COVID-19 tender scams. 2020, July 7. Newsday

73. Chitemba, B. Deputy health minister in tender storm. 2020, October 18. The Sunday Mail

Importantly, there exists a lack of effective oversight and checks and balances to ensure procurement regulations are followed.

There are some legitimate reasons for evading standard public procurement rules, such as the need for speed during emergencies, but these reasons can be misused to facilitate public procurement.⁷⁴ In the context of the COVID-19 pandemic, the emergency procurement measures that have been put in place have been abused to facilitate illicit procurement. GOZ has implemented Section 59 of the PPDPA Act which notes that ***“where, owing to a catastrophic event, there is an urgent [procurement] need” Government can use “the single-source selection method.”*** This method allows fast purchase as MOHCC can select one supplier and does not need to invite competitive bids.⁷⁵ MOHCC only has to prepare terms of reference (TORs), draw up a short-list of potential suppliers and select one supplier from the list. The supplier then must submit a bid to facilitate a negotiation for a procurement contract. The law requires transparency in all contract awards including emergency single-source procurement. Therefore, MOHCC should publish the contract awards on the PRAZ website.⁷⁶ To date, however, PRAZ has never published a single contract award or procurement notice on its website.⁷⁷ This is in contravention of the law and limits the ability of parliamentarians, civil society and citizens to hold GOZ accountable for public spending during the COVID-19 pandemic. The desire by GOZ to be seen as responding quickly to COVID-19 creates

the risk of choosing unqualified suppliers, obtaining poor quality goods and services, entering into poorly written contracts and failing to achieve value-for-money (VfM).

Findings show that drugs are the most affected by illicit procurement because the supply chain for drugs has been seen by sector experts as having leakages at every level which also affect drugs acquired by donors. A source in the medical field indicated that public officials falsify the three quotations that are required for public procurement of drugs and other supplies, and then award their company the contract. This is further enabled by the fact that there are no PRAZ approved suppliers for such negligibly small daily procurements like for green vegetables. At the primary facility level, procurement contracts for food items and some services are alleged to be awarded to public health workers at the facilities or their relatives often-times without following due process.

Box 6: Key weak points enabling corrupt procurement:

The greatest sums involved in corrupt procurement are at the national level, where health agencies conduct large tenders for equipment, supplies, medicines, and services. Key weak points in processes for procurement at the central level include:

- The lack of due diligence in registering suppliers by PRAZ
- The discretion enjoyed by a few MOHCC officials to determine the specifications for a tender, which may favour one supplier over others
- The practice of sharing tenders with favoured suppliers before sharing them publicly

74. Soreide, T. 2002. Corruption in public procurement: Causes, consequences and cures

75. Section 65(1) of the Public Procurement and Disposal of Public Assets Act

76. Section 68 of the Public Procurement and Disposal of Public Assets Act

77. A web page exists for procurement award notices but has no record under it: <https://portal.praz.org.zw/awards>

While the largest procurements occur at the national level, significant procurement is handled directly by facilities. Key weak points at the facility level include:

- The discretion enjoyed by a few officials in acquiring three quotations from suppliers
- The evaluation of quotations (especially in primary facilities) where a small number of officials can allocate contracts to each other
- Processes for receiving procured goods, where quantities and qualities of supplies can be easily falsified

Donor aid is also affected by illicit procurement. Some aid is channelled through GOZ's public financial management system and is affected by the illicit practices prevalent in public procurement. During the cholera outbreak in 2018, Econet donated US\$10 million through a National Cholera Crisis Fund which the urban councils were supposed to use to procure medical supplies. Harare City Council officials engaged in overpriced contracting which was revealed by Econet's main shareholder, Strive Masiyiwa who noted that "gloves [that are] worth US\$3 were suddenly [priced at] US\$65."⁷⁸ The OAG has uncovered instances where health facilities had no supporting documentation for expenditure running into thousands of dollars.⁷⁹

4.3. Petty corruption

Petty corruption refers to small scale corrupt practices, usually taking place at the point of service delivery or programming

by lower-level public officials within public health facilities and local governments. Petty corruption is common in the health system as in other sectors, typically taking the forms of bribery, nepotism and other forms of self-dealing.⁸⁰ A survey of 403 executive managers in Zimbabwe's private sector found that 48% regarded officials from local government health departments as corrupt.⁸¹

While petty corruption is understood simplistically by some stakeholders to be driven by greed, it is incentivized by the low and unreliable incomes that the public sector workers earn and enabled by the weak accountability in the public health system. Local authority workers often go for many months without receiving salaries which leads some workers to find alternative ways of making money from their jobs. To provide an extreme example, Chitungwiza Municipality workers, including local government health workers, have not received full salaries for almost four years, meaning that local public officials must find other ways to make ends meet.⁸² Petty corruption is also incentivized through routine conflicts of interest such as public health workers using public resources for their private practice businesses – for example, the study found that public hospital doctors bring samples from their private practice for free testing at the public hospital laboratories. There also remains a general lack of compliance by local businesses and the informal sector with key regulations, such as local government health by-laws and national public health requirements. Further, the dispersed nature of petty corruption makes it difficult to address while the centralization of doling out punitive sanctions to the Public

78. Mudzingwa, F. Strive Masiyiwa Promises to Name and Shame Municipal Officers Trying to Take Advantage of Econet's Cholera Response Funds. 2018, September 17. TechZim
79. Office of the Auditor General. 2019. Report of the Auditor-General for the Financial Year Ended December 31, 2018 on State Enterprises and Parastatals

80. Chene, M. 2015. Zimbabwe: Overview of corruption in the health and education sectors and in local governments. Transparency International.

81. CZI, ZNCC and SMEA. 2016. Zimbabwe Corruption in Business Survey

82. Chidakwa, B. Zimbabwe: Council Workers Go 50 Months Without Full Salaries. 2020, May 4. The Herald

Service Commission severely restricts the ability of supervisors to hold their subordinates to account.

Respondents report far reaching effects of petty corruption within the health sector. This includes an overall decline in the “standard of practice” of health professionals, as is evidenced by pharmacies with inadequate storage conditions for some medication continuing to stock these drugs with impunity and proliferation of food outlets with inadequate health standards. Petty corruption directly undermines efforts at ensuring equity within the healthcare system as it leads to preferential treatment of patients in public health facilities that can pay informal fees.

Bribery

The regulatory processes in the health sector are particularly vulnerable to bribery. Various licenses are awarded by different regulatory agencies for operating business premises, practicing as a health professional, manufacturing foodstuffs and beverages, manufacturing medication and growing some illicit crops such as marijuana among others.

In turn, businesses which are already operating in an economy in which regulatory hurdles are a norm, are often willing to pay bribes to expedite the issuance of the licenses and ensure the certainty of an approval. Businesses are regularly inspected by Local authority health departments inspect business premises to ensure they are complying with public health by-laws.

Box 7: Regulatory agencies in the health sector

- Medicines Control Authority of Zimbabwe (MCAZ) – regulates the production, import and use of medicines
- Health Professions Authority of Zimbabwe (HPA) - umbrella body for the seven health profession councils; appellant body for any dispute between health practitioners and their councils; and protection of public interest in the health sector
- Procurement Regulatory Authority of Zimbabwe (PRAZ) – regulates public procurement
- Health Service Board (HSB) – manages HRH
- Local authorities – licensing of health institutions

The inspectors often extract informal payments from shops and pharmacies that are not compliant with the by-laws. A survey of senior managers of 403 businesses of all sizes in Zimbabwe found that they ranked local authority health departments as the 4th most corrupt GOZ institution, with 48% of the respondents perceiving them as corrupt.⁸³ MCAZ officials have also been accused of taking bribes from pharmacies so as to allow them to continue operating when they find them flouting MCAZ regulations while MOHCC’s Port Health Inspectorate who man the country’s borders are also accused of taking bribes to allow smugglers to cross borders with medicines illegally.

While licensing is most prone to bribery, some other decisions are also affected by bribery, albeit at a lesser extent. This

includes provision of exemptions to pay for public health services and obtaining entry into public nursing schools. The study found that staff at professional boards take bribes in order to falsify continuous development points (CDP) and issue licenses to unqualified health professionals; elected officials and traditional leaders⁸⁴ extract bribes in return for letters permitting patients to be exempted from paying user fees at health facilities; and, MOHCC officials take bribes for issuance of licenses and approvals. In a survey, Transparency International Zimbabwe (TIZ) found that 58% of respondents who had used the public health system had been asked to pay a bribe to access medical services, while 60% had paid a bribe to speed up their access to health services.⁸⁵

Self-dealing by public officials

Key informants also revealed that some public officials abuse public resources in the public health system to enrich themselves. The study heard it is a common practice for public sector doctors to have private practices on the side. The Chairman of the Health Service Board (HSB) which regulate HRH noted that in order to incentivize experienced doctors to work in the public health system, the HSB now allows senior doctors to have private practices and has even “given them permission to do private practice during working hours” and to admit their private patients into public hospitals for operations, while some hospitals have established private wings that these senior doctors can have their patients admitted into.⁸⁶ This creates conflicts of interest as senior doctors who admit their patients from

private practice into public facilities often charge the patients from their private practices for goods and services that come from the public sector. The study found that some doctors go on to bring in patients of other doctors who do not work at the public facility and are paid for it. A community health expert revealed that a significant number of doctors steal drugs from public health facilities and sell them in their private practice, often to the same patients who cannot access the drugs from the public health facilities.

The study found that doctors who had both public and private practices bring in samples from their private practice for testing at the public facility labs and pay the lab scientists bribes to get the tests done. The doctors' private practices would then charge the patients for the tests. It was also revealed that some lab scientists collude with private sector laboratories who provide backup to the public sector lab to sabotage Government laboratory equipment so as to create business for the private sector laboratories. Further, the study found that nepotism is common in the public health sector exemplified by public health workers who get their relatives treated for free.

The Auditor General found that in some public health facilities, members of the Hospital Management Board do not have taxes withheld on the fees paid to them even though they did not have valid tax clearance certificates. In addition, the Auditor General found that tax was not charged on “allowances and fees such as cell-phone, fuel and school fees paid to executive management”.⁸⁷

84. Village heads are empowered to issue exemptions for vulnerable citizens in their communities to obtain medical attention in the public facilities without payment
85. Transparency International Zimbabwe. 2019. Gender and Corruption in Zimbabwe 2019.

86. Dube, G. Zimbabwe Senior Doctors Threaten to Join Strike. 2019, October 3. VOA

87. Office of the Auditor General. 2019. Report of the Auditor-General for the Financial Year Ended December 31, 2018 on State Enterprises and Parastatals

4.4 Smuggling

Medical supplies, and especially drugs, are smuggled across Zimbabwe's borders. Smuggling of drugs poses an immense danger to the health of Zimbabwe's citizens. One health expert noted that, "some life-saving drugs like insulin are very sensitive to temperature and the conditions they are smuggled under are likely to deactivate them which poses a real danger of death for the patients who use the drugs." Most drugs have some storage requirements and are potentially similarly affected by smuggling, more so when they are transported together with other goods such as stockfeed and fuel. Other drugs could be fake or sub-standard, containing less potency than is advertised which creates health risks for users.

In addition, smuggling undermines the pharmaceutical industry, tax-paying manufacturers and registered importers of drugs. The local Pharmaceuticals industry ranks smuggling of drugs as one of its top four challenges and estimates that, after excluding donated drugs, 20% of the drugs consumed in Zimbabwe are smuggled into the country – an estimated value of US\$60 million a year.⁸⁸

A key driver of smuggling is the high demand for low-priced drugs in Zimbabwe. A large proportion (70%)⁸⁹ of Zimbabweans is poor and an estimated 90% of Zimbabweans do not have medical insurance.⁹⁰ This has two impacts. First, citizens without medical aid cover seek to purchase the cheapest available medication. Second, the minimally financed medical aid insurance companies seek to cut costs by setting low prices that

they will pay Pharmacies for medication and leave the balance to the insured person, who is unlikely to be willing to want to pay it. Pharmacies are therefore incentivized to seek the cheapest available drugs which can be covered in full by the medical insurance companies and find a market among the impoverished majority of citizens. One doctor rationalized that, "smuggling the drugs is a way for [retail pharmacies] to not charge [patients] too much." A community health activist noted that retail pharmacies are flouting laws by selling prescription drugs to people without prescriptions who may be avoiding the cost of consulting a doctor first.

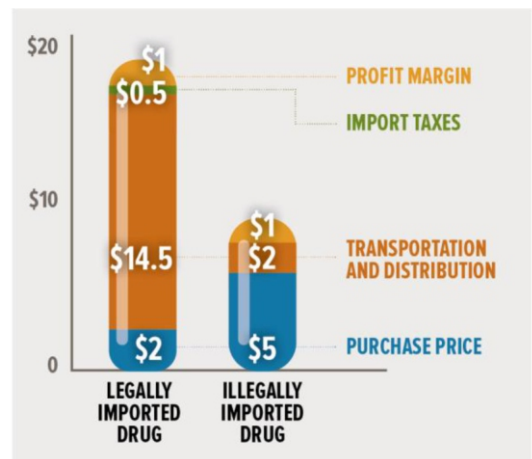


Figure 5: Comparison of cost structures of legally imported and smuggled drugs

Drugs that are legally imported into Zimbabwe or manufactured locally are more expensive than smuggled drugs. One pharmacist explained, "it is three times cheaper to have a runner bring you Paracetamol from Zambia than to order Paracetamol from Varichem [a local manufacturer] while runners sell Nefidipine at US\$3 and PCD [another local manufacturer] sells it at US\$5. It will be the same product." The price differential is a

88. Authors' calculation based on Zimstat data and other secondary literature
89. ZimStat. 2017. Poverty, Income, Consumption and Expenditure Survey
90. Gwati, G. 2014. Desk Review of purchasing arrangements for public health services in Zimbabwe

result of multiple factors: smugglers do not pay taxes, they buy stolen drugs from neighbouring countries that are sold for less than their value, and some drugs that are counterfeit or of poor quality. By contrast, formally traded drugs are relatively expensive because of the high costs of doing business in Zimbabwe, i.e. the costs of licencing drugs, the costs of financing and the high cost of accessing foreign currency.

MCAZ policies also drive smuggling. MCAZ does not allow retail pharmacies to import drugs except in the case that they are not locally available, often times due to “foreign currency shortages leading to failure of importers of registered products accessing foreign currency and thus failing to supply registered products.”⁹¹ Retail pharmacists complained that this restriction allows companies that are licenced to import and distribute the drugs to overcharge for them. A retail pharmacist illustrated this by observing that, “*A tin of paracetamol is sold by Indian manufacturers for US\$1.70. In Zambia it is sold by importers to local retail pharmacies at US\$5 while in Zimbabwe it is sold by PCD at US\$17.*” In many instances, patients are prescribed to use drugs that are not currently registered in Zimbabwe. Approved wholesalers are required to register such drugs – a process that takes on average, 600 days⁹² and costs US\$2,500 to US\$3,000 dollars,⁹³ slightly more than Zambia where registration costs US\$1,700 to US\$2,800.⁹⁴ These costs and the onerous process are seen as disincentivizing registration of drugs that are infrequently required and therefore incentivizing smuggling of such drugs. A retail pharmacist noted that, “it takes

anything from six months to three years just to register a new product and the costs are exorbitant. This leads to patients smuggling in drugs that are unavailable locally.” MCAZ allows the importation of such drugs in two ways: (i) retail pharmacists make a section 75 application per each prescription - in 2017, 8,976 such applications were processed; and (ii) approved wholesalers can make a Section 75 application to import unregistered drugs in bulk – in 2017, 1,089 such applications were processed.⁹⁵ MCAZ reports that the processing time is 5 days, however retail pharmacists complain that the process is time consuming and a single prescription does not often justify the time and cost of filling in the application forms. Further, the retail pharmacists would then have to access foreign currency from the formal financial system for importing the drugs, a process which until very recently was likely to be futile or be approved after a very lengthy wait. The recent introduction of the forex auction system has substantially improved access to foreign currency for the pharmaceutical industry.

Observers also note that “MCAZ is not equipped” to effectively monitor the smuggling of drugs. Legislation is only punitive to pharmacies who are caught buying smuggled drugs, while the smugglers themselves cannot be dealt with by MCAZ as “they are not licenced by MCAZ” but fall under ZRP’s jurisdiction which treats possession of smuggled medical drugs as petty crime that attracts only attracts a small fine. MCAZ has noted that “illegal sale of medicines by unlicensed persons in unlicensed premises such as street markets [has] persisted in spite of the public warnings to consumers and periodic blitz with law enforcement agents to confiscate medicines.”⁹⁶ Further, MCAZ is

91. MCAZ. 2018. Annual Report 2017

92. *Ibid.*

93. GOZ. 2020. Statutory Instrument 22 of 2020. Government Gazette

94. Zambia Medicines Regulatory Authority. 2017. Schedule of Fees as per SI. No. 38

95. MCAZ. 2018. Annual Report 2017

96. MCAZ. 2018. Annual Report 2017

not present at all the country's borders to monitor smuggling of drugs where a community health activist noted that "smugglers pay bribes" to ZIMRA's customs officials and Port Health officials to get their contraband across the border.

MCAZ officials are only physically present at Harare International Airport on weekdays, while at all other borders MCAZ relies on ZIMRA and Port Health officials to monitor smuggling and importation of unregistered drugs.⁹⁷

COST & TIME FOR REGISTERING AND IMPORTING A MEDICAL DRUG INTO ZIMBABWE (IMPORTED AS FINISHED PRODUCT)

APPLICATION FOR REGISTRATION
US\$2,500 - 3,000

6 MONTHS TO 3 YEARS

APPLICATION FOR EXPEDITED REVIEW ANY AMENDMENT TO APPLICATION
US\$4,000 - 4,500 US\$250 - 400per amendment

COST & TIME FOR IMPORTING UNREGISTERED DRUGS INTO ZIMBABWE (AS PER SECTION 75)

APPLICATION FOR ISSUE OF A BULK SECTION 75 AUTHORIZATION LETTER. ONLY FOR APPROVED WHOLESALE DEALERS
US\$7.40

5 DAYS

APPLICATION FOR ISSUE OF SECTION 75 AUTHORIZATION LETTER FOR AN INDIVIDUAL PRESCRIPTION
US\$0.37

2 WEEKS

Box 7: Drivers of smuggling

Smuggling is driven by Zimbabwe's position as a key node in the regional transport infrastructure, its porous borders, and the high cost of locally manufactured drugs. Stringent laws against importation of drugs that are locally available as well as high customs duty also serve as key factors. Furthermore, weak legislation and enforcement against smuggling of drugs and weak monitoring of this illicit value chain further enable the trade.

Findings show that drugs are mainly smuggling into the country, however some drugs are smuggled out of Zimbabwe. The main source countries for smuggled drugs are Zimbabwe's neighbours: Botswana, Mozambique, South Africa and Zambia. The main destination countries for drugs smuggled out of Zimbabwe are Mozambique and South Africa. In some unique cases, drugs that are legally exported from Zimbabwe find their way back into the country through smuggling; this becomes economically feasible when these drugs are stolen from the importing country's health facilities. A source in the pharmaceutical industry cited an example where flu medication was exported to Zambia's public health system by CAPS, an SOE, and due to leakages in Zambia, found its way back to Zimbabwe through smuggling. Weak public health supply chain systems in neighbouring countries are therefore an exogenous factor that enables smuggling of drugs into Zimbabwe.

Smuggling of drugs is done across both legal and illegal crossing points. Smugglers are commonly known as runners and include travelers stashing drugs at the bottom of a bag to sophisticated syndicates that allegedly comprise of public sector doctors and pharmacists who use their proximity to decision makers to facilitate the smuggling and sell the drugs in their privately-owned pharmacies, surgeries and hospitals. There is an informal transporting sub-sector that evades import taxes at Zimbabwe's "porous borders" through bribery. This informal transport sub-sector has occupied the market space created by the demand by the large Zimbabwean diaspora in neighbouring countries for a means to send

money and goods back home as cheaply as possible. This creates an enabling environment for smuggling.

Illicit drugs are also smuggled together with, or using the same means as, the drugs for licit purposes. These drugs range from cough syrups that are abused to hard drugs. Illicit drugs are not covered in this study.

4.5 Theft

The theft of drugs and other medical supplies from Zimbabwe's health system deprives poor citizens from access to subsidized medication, leads to transfer of public wealth to the pockets of a few individuals and undermines the manufacturers and registered importers of drugs.

Theft takes place in many areas of the health sector, but most frequently involves theft of drugs from the public health supply chain, especially from public health facilities and NatPharm. Further, medical supplies provided by aid organizations are also stolen. Theft also affects other medical supplies and paraphernalia used in public, private and aid sub-sectors of the health sector such as linen, curtains, syringes and PPE. Theft in the public health system is perpetrated by a wide range of public health workers, ranging from doctors and pharmacists who take drugs from government institutions to their private surgeries and pharmacies, nurses, to officials responsible for managing hospital stores departments and NatPharm officials.

Theft is driven by low incomes in the public sector⁹⁸ poor corporate governance in state institutions which manifests in weak supply chain management systems, lack of

98. Salaries remain low when benchmarked against other countries in the region, which contributes to high attrition rates;

transparency and accountability, patronage and a high demand for cheap medical supplies. Classic rent-seeking is compounded by the very low incomes that public health officials receive in motivating them to steal. A leading expert in public health noted that “low remuneration is one of the drivers of illicit activities” while another source added that “[officials] only steal medicines for resale because they are hard pressed and need to survive.” A registered nurse in the public sector earns the equivalent of USD 30 per month⁹⁹ – a fraction of what registered nurses in Zambia and Mozambique earn - USD 295 and

529 per month¹⁰⁰ respectively. Prior to the onset of inflation in 2018, nurses were earning USD 520 per month. Health experts note that it is these low incomes that lead to nurses “taking ready-to-use-therapeutic-food (RUTF) meant for patients and cooking it at home” and doctors taking drugs that have subsidized prices from the public sector and selling them in hard currency. A lab scientist who has worked in both Zimbabwe’s and Botswana’s public health facilities compared the two noting that, “health workers in Botswana are paid enough to not think of engaging in corruption whereas in Zimbabwe health workers are underpaid and want to earn more.” A community health expert pointed out that theft became a challenge in the public health sector in the mid-90s when structural economic reforms led to job losses and stagnation of wages.

Poor governance enables theft. The poor governance is epitomized by lack of basic checks and balances – for example, some primary health facilities are under-staffed and the same officer responsible for procurement is responsible for quality assurance of the procured goods and

services. A former junior doctor in the public sector noted that theft is more likely to occur in primary health facilities in the public sector like clinics, which due to their small size have fewer staff members and may have “one procurement officer who conducts the procurement and conducts the quality assurance of the goods that are delivered [therefore] such a person is likelier to engage in corruption”. The junior doctor contrasted this to large facilities where there are multiple officials participating in the various steps of public procurement.

Stolen drugs have a similar market as smuggled drugs. They are sold to patients, pharmacists and the public. A pharmacy owner described how some health workers sell stolen drugs to “a few unethical pharmacies” and how other health workers sell the drugs through *runners*, individuals who act as middlemen between the nurses and pharmacies. The pharmacist noted that most of these *runners* are the same *runners* smuggling drugs into the country. Pharmacists are incentivized to buy the stolen drugs because they are “authentic products that are sold for way less than their actual price” thereby creating a rent that the pharmacists can easily earn. Health officials are reported to also sell stolen drugs directly to patients in the facilities they steal from who would have failed to get the drugs.

Box 9: Institutional weaknesses that enable theft

- Conflicts of interest in some roles due to inadequate staff numbers
- Onerous process of reporting theft
- Weak oversight over drug storage systems

99. Fin24. We are paupers receiving slave wages, say Zimbabwe nurses as union calls for strike. 2020, July 1.

An operator in the pharmaceuticals industry noted that stolen drugs are sometimes stored in a way that affects their quality thereby creating a health risk for those who then use the drugs. A public health expert in the aid industry added that drugs such as insulin, which are rendered ineffective by room temperature, are a serious health risk as taking a tainted dose can lead to death.

4.6 Donor safeguards against illicit finance

Donors provide 40% of funding to Zimbabwe's health sector and the bulk of its medicines, and some of the donors use the country's public systems to distribute these medical supplies. Because of some of the risks cited in this report, donors put in place safeguards for the funding they provide to Zimbabwe's health sector, provided capacity development for public officials and assisted in strengthening public health systems. This includes assessments of the supply chain for medical supplies, strengthening quality assurance of health products by the Medicines Control Authority of Zimbabwe (MCAZ), upgrades and rehabilitation of storage facilities, improving record keeping and information management, training of key staff in supply chain management¹⁰¹ and pooling procurement across many countries benefitting from the donor funding to centralize procurement which brings benefits of lower prices, consistent supplies and risk mitigation!¹⁰²

The scope of this study was focused on the public health system and public funds utilized in it. Therefore, the study did not obtain enough data to evaluate the effectiveness of these safeguards, but

some level of risks remain, as is conveyed by audit reports. An audit of Global Fund Grants in Zimbabwe in 2020 notes that "gaps exist in legibility and retrievability of stock documentation", "MOHCC and Natpharm have no key performance indicators on timeliness/accuracy of receipts entered by NatPharm"; found small variances between stocks of medicines and NatPharm's records and at health facility level found that "physical stocks of ARVs and lab items in visited facilities varied from stock-cards by over 30%."¹⁰³ This highlights how the risks to donor funding posed by the drivers of theft, corrupt procurement and smuggling identified in this study are already being monitored by donors. These safeguards provide some mechanisms that could influence GOZ practice as is detailed in the recommendations.

101. UNDP. n.d. Strengthening the procurement and supply chain for health in Zimbabwe
102. US Government Accountability Office. 2013. President's Emergency Plan For Aids Relief: Drug Supply Chains Are Stronger, but More Steps Are Needed to Reduce Risks
103. The Global Fund Office of the Inspector General. 2020. Audit Report: Global Fund Grants in Zimbabwe

5. Notable Observations and Trends



Illicit finance has an overall negative impact on the health sector which manifests in various forms – public funds are wasted, citizens are underserved, public sector workers and donors are demoralized, lives are put at risk, private businesses become unsustainable and the capacity of public institutions is hollowed out. These conditions contribute to a system in which a fifth of child births take place with no skilled health professional present¹⁰⁴, while post-natal care is compromised. Similarly, it feeds into an environment in which five in every hundred infants dies before they turn five years old while one in every two hundred women who give birth dies while giving birth.

Several key trends and observations emerge from the study's findings. These are detailed below:

The financing of the health sector is fragmented which reduces GOZ's ability to coordinate a response to illicit finance. There is no common framework in practice for administration of financing of the health sector: budget allocations, AIDS levy, Airtime Health Tax and user fees are all managed differently and often with limited to no interaction. This reduces the economies of scale and fails to harness the opportunity to manage risks, including risks related to illicit finance, in a unified manner.

The health sector is receiving a higher share of public funds and this may attract rent-seeking. Historically, the

health sector has been under-funded and received a small share of foreign currency allocations from RBZ compared to other sectors such as energy and agriculture. The sector also contributes negligibly to exports. This has meant the rents in the sector were noticeably smaller than in other sectors of the economy. To illustrate this point – during the five-year Government of National Unity (GNU), President Robert Mugabe and Prime Minister Morgan Tsvangirai spent more money on trips abroad than the total amount of budget allocations made to the health sector over the same five year period.^{105,106} However, under the Mnangagwa administration there has been increased public funding of the health sector (as a share of the total national budget). This puts the public health system at an increased risk of corruption as evidenced by the Drax Consul SAGL scandal.¹⁰⁷

Under conditions of increased financing and a more attractive investment climate, collusion between senior public officials and the private sector is likely to become a key form of illicit finance in the sector. The proliferation of illicit finance and patronage networks that benefit from it creates an environment in the public health sector where appointments to key positions are not done in a fully meritocratic way, but where individuals who are best able to serve the interests of patrons are put in positions of power in the MOHCC, public health facilities and regulatory agencies and SOEs.

104. UNICEF. 2020. Zimbabwe Country Profile

105. Blair, D. Zimbabwe: How we aid profligacy. 2012, February 20. The Telegraph.

106. Transparency International. 2015. Zimbabwe: Overview of corruption in the health and education sectors and in local governments

107. Bulawayo24. Mnangagwa's minister implicated in purchase of non-usable hospital equipment. 2020, February 4.

Lower-level public actors are most involved in illicit finance in the health sector. The key actors in illicit finance occupy lower-level positions in the public sector. There is, therefore, less coordinated incidence of illicit finance epitomized by the prominence of dispersed illicit activities such as theft, smuggling and corrupt procurement at facility level.

There is consequently less political financing using the proceeds of illicit finance as compared to other sectors. The key motivation for illicit finance in the health sector is rent-seeking. Political financing provides little motivation for illicit finance in the sector, in contrast to other sectors such as agriculture and mining. The key political consideration that was observed is in the appointment of Village Health Workers by councillors who, across the political divide, tend to select members of their parties.

Illicit finance across the economy negatively affects HRH. As found in studies of illicit finance in the mining, energy, agricultural and transport sectors, illicit finance leads to a significant reduction in tax revenues, loss of public funds to corrupt activities and large portions of allocations of the limited public funding are made to budget lines that benefit collusive arrangements between public officials and their associates. This leaves the health sector under-funded and the MOHCC unable to fill all its posts or pay health professionals a decent salary. Further, some forms of illicit finance drive inflation and erosion of the local currency. For example, collusion in the Command Agriculture Program led to an overnight depreciation of the ZW\$ by 80% in July 2019. This consequently meant the

incomes of HRH in the public sector lost 80% of their value overnight and is a stark example of how many other cases of illicit finance affect incomes of HRH.

Illicit finance affects donor funding more in the health sector than in other sectors. The health sector is one of the top sectors that receive financing from donors in Zimbabwe, together with agriculture, food aid and governance. There is more use of country systems in the health sector compared with other sectors. Some donors use the public procurement and the NatPharm distribution systems for the acquisition and delivery of medical supplies to health facilities. This puts donor funding at risk of being affected by illicit finance. The manifestation of this risk combined with the aforementioned impacts of illicit finance are likely to make donors disillusioned with the prospects of success in Zimbabwe and, at worst, could lead to donor fatigue and ultimately a decline in donor aid to the health sector.

6. Conclusion and Recommendations

Illicit finance is prevalent across the health sector principally in the forms of corrupt procurement, cross-border smuggling of medical supplies, and theft of medical supplies. To a lesser extent, health sector illicit finance occurs as petty corruption and collusion between public officials and the private sector.

Illicit finance in the health sector is enabled by myriad interests and institutional weaknesses, manifesting in many forms. It therefore requires action on multiple fronts to meaningfully reduce its occurrence. There are a broad set of regional and global experiences that can inform practice within Zimbabwe, and such approaches must be customized to the unique political realities of the local context.

6.1. Recommendations

This report shows that illicit finance is deeply entrenched within the health sector and the wider governance system in Zimbabwe. At a senior level, health sector illicit finance operates within an intricate patronage system. At the same time, diverse actors at the ground level are incentivized to participate in petty corruption due to the lack of reliable and sufficient remuneration and the lack of credible sanctions on their behaviour. For these and other reasons outlined in this report, there does not exist a favourable environment for deep reforms and structural changes aimed at systematically addressing the causes of illicit finance in Zimbabwe, including in the health sector. At the same time, it is important that

champions of reform who operate in the health sector and outside of it have a clear agenda for near- and medium-term change.

This section begins (in sub-section 6.1.1.) by presenting recommendations for actors operating in the healthcare system. This is followed (in 6.1.2) by recommendations for champions of reform who are operating outside of the health system.

6.1.1. Recommendations for actors in the health sector

Despite the inherent challenge of reforming public health institutions, it is possible to identify motivated champions of good governance and curbing illicit finance across the health sector. These include private sector actors who are harmed by illicit finance such as pharmaceutical manufacturers and distributors; civil society organizations and development agencies that are implementing programmes in the health sector; and well-intentioned public health workers who, despite having limited power, are organized through associations.



MOHCC is the nerve center for the public health sector and the study makes the following recommendations to the Ministry:

i. The MOHCC should, in collaboration with the Zimbabwe Anti-Corruption Commission (ZACC), strengthen its anti-corruption reporting system. The system should ensure the protection of those who make reports in line with the articles of the United Nations Convention against Corruption (UNCAC), namely articles 17 (embezzlement, misappropriation or other diversion of property by a public official), 18 (trading in influence), 26 (liability of legal persons) and 33 (protection of reporting persons). Information on how to use the anti-corruption reporting system should be widely availed at all public and private health institutions and at the country's points of exit and entry. In general, GOZ should ensure the effective implementation of whistle-blower mechanisms and protections in line with UNCAC Article 33 and carry out full prosecution of corruption cases. In addition, MOHCC should strengthen its internal audit unit to monitor theft of drugs effectively and make the process of reporting theft anonymous and easy. MOHCC should fully implement the Freedom of Information Act by, among other actions, expediting the appointment of information officers in every public entity in the health sector. MOHCC should maintain a publicly accessible registry of all information requests that are made to these information officers and how they would have been handled. Civil society should take advantage of progressive clauses in the recently enacted Freedom of Information Act¹⁰⁸ to scrutinize government records.

ii. The MOHCC should strengthen its public procurement processes. In collaboration with PRAZ, MOHCC should establish regularly updated market price guides for commonly procured goods and services. These guides should be used by all entities that procure goods and services for the health sector using public funds. In enforcing the guides, the MOHCC should require declaration of justifications for any procurement with significant variances from the benchmark prices. MOHCC should also ensure that frontline staff (doctors, nurses and other technical staff) are sufficiently represented in the committees that develop TORs for procurement, evaluate the bids that are made and conduct quality assurance of the goods and services that are delivered. In addition, PRAZ must conduct due diligence on firms and individuals that apply to it for registration, paying particular attention to the applicants' past performance and capacity to deliver. Lastly, MOHCC and MOFED must recover the payments made for public contracts that are won illegally in line with the High Court ruling that if a tender is awarded without properly following the law, the contract is legally null and void, and if any payment has been made it must be returned.

iii. MCAZ and the Port Health Inspectorate must more actively curb smuggling of drugs by manning borders during all hours that their open. The leadership of these institutions must incentivize inspectors to stem smuggling and withstand offers for bribes, through decent incomes, punitive sanctions against those who take bribes and meritocratic promotions. The Zimbabwe Republic Police and judiciary could support these

108. The Herald. AIPPA scrapped...New Freedom of Information Bill signed into law. July 2, 2020

measures by taking a tougher stance against smuggling of drugs and illegal sales of drugs. MCAZ could collaborate with sister agencies from neighbouring countries through the SADC Pharmaceutical Programme to coordinate interventions aimed at curbing smuggling of drugs across borders in the region. MCAZ is already collaborating with other regional agencies in the Registration Harmonisation project which seeks to strengthen information sharing and establish a common system for registering medicines. A possible short-term step for MCAZ is in reducing the time it takes for retail pharmacists to have their Section 75 applications for individual prescriptions processed.

iv. There is need for the OPC and MOHCC to demonstrate political will to safeguard medical drugs in the public supply chain over which NatPharm and public health facilities play a key role. Public entities in the supply chain have benefited from multiple donor-funded interventions to strengthen their capacity and technical know-how of supply-chain safeguards however what is lacking is the political will to implement these safeguards.

v. MOFED should strengthen public financial management in the public health system. MOFED should provide streamlined and effective coordination of all public funding for the health sector to ensure unified management and mitigation of risks of illicit finance. This could be done by ensuring MOFED and MOHCC seek approval for the budgets and workplans for the AIDS Levy and the Airtime Health Levy

from Parliament in line with the Constitution and a Supreme Court ruling.¹⁰⁹

Alternatively, these retention and statutory funds (RSFs) should fall under the National Budget and be managed from the Consolidated Revenue Fund (CRF) over which Parliament has oversight, and the information is made already made publicly available. MOFED should also strengthen MOHCC's ability to manage PPPs by ensuring good quality valuation of all state assets that will be used in PPPs is conducted, requiring PPPs to be procured through competitive tendering under PRAZ's oversight and collaborating with MOHCC to submit to Parliament (and potentially make public) regular financial and operational reports on PPPs in the health sector. These reports could also be made public in line with the recently enacted Freedom of Information Act, which categorizes such reports as information that citizens have a right to access.

MOFED could be motivated to fulfill these recommendations because it has the unenviable role of satisfying the rent-seeking needs of patronage networks and delivering financing for social needs. The pressure, often citizen-led, for the latter has led MOFED to occasionally undercut patronage networks to finance social priorities. For example, in 2019 and 2020 MOFED fought powerful vested interests to remove a subsidy benefiting millers of maize and wheat, which benefited powerful actors within the Presidium, military, RBZ and private sector (this is covered in the APEA study of illicit finance in the Agricultural sector).

109. In a 2013 Supreme Court case, case number S-44-13, ZIMRA challenged a directive by RBZ that commercial banks with which ZIMRA banked should transfer ZIMRA's deposits to RBZ. Two of the banks complied. The Supreme Court ruled that Section 302 of the Constitution of Zimbabwe that requires all public funds to be overseen by Parliament applies to all Government Institutions, and the Executive could not unilaterally contravene this section.

vi. The Health Services Board (HSB) take measures to limit conflicts of interest among HRH.

HSB should ensure that all positions that are involved in all stages of procurement and management of the drugs supply chain are filled at all public health facilities. This will address the challenge of having some public officials who have multiple roles which lead to conflicts of interest. HSB should also effectively monitor senior doctors that it has allowed to operate private practices and use public health facilities for their private patients by, together with the health facilities, fine-tuning cost-recovery mechanisms (which consist of contracts and standard operating procedures) that ensure that all public goods and services used for the private practices are fully paid for. In the medium to long-term, GOZ must ensure that doctors in public practice are fairly remunerated and the HSB should stop or significantly limit the on-going practice of allowing senior doctors to operate private practices during their working hours.

Thirdly, the HSB should, together with the rest of the GOZ, implement systemic and regular asset disclosure process for all public officials to the Zimbabwe Anti-Corruption Commission (ZACC) through the signing of a Code of Conduct and declaring both assets and liabilities on a form that would be publicly available. For senior public officials, the asset disclosure should be made public and renewed annually, and failure to make or renew a declaration should be a criminal offence. In 2018, President Mnangagwa requested asset disclosures by senior public officials

except for himself and his deputies. While this action is an encouraging step, it falls short of the independent, systemic and regular disclosures that will curtail illicit behavior. The Commonwealth Model Act on Integrity in Public Life's clauses on asset disclosure could serve as inspiration for these reforms. Most importantly, however, GOZ should, in the short to medium term, ensure that public health officials are remunerated fairly in line with regional trends. Local governments, in particular, should pay their staff on time.

The private sector too has a role to play in improving transparency. Wherever possible, transparency within the private sector should be prioritized as this allows the media, civil society, and citizens to hold private sector companies to account. Similarly, beneficial ownership registries are a critical building block for ensuring that there is full and transparent knowledge of individuals with a financial stake in corporate entities. Anonymous companies are a key vehicle for stolen funds; in one World Bank study, they were used in 70% of 200 cases of grand corruption reviewed!¹¹⁰

With technical assistance from the World Bank, GOZ has enacted a modern Companies and Other Business Entities Act which regulates the private sector. The Act requires companies to keep and maintain a register of the beneficial owners¹¹¹ of the company and to file this with the Registrar of Companies.¹¹² However, the Registrar of Companies has announced that the beneficial registry will not be made public and will only be accessible to the Financial Intelligence Unit (FIU) of the RBZ and law enforcement agencies.¹¹³

110. Kumar, L. 2019, June 12. Anonymous companies – A way forward. Global Financial Integrity.

111. A beneficial owner (i.e. the real or true owner) is defined as an individual who directly or indirectly holds either more than twenty percent of the company's shares or more than twenty percent of the company's voting rights or exercises significant control over the company.

112. Section 72 of the Companies and Other Business Entities Act

113. Hobi, A. 2020. Is the New Beneficial Ownership Register a Transparency Game Changer for Zimbabwe?

Citizens and citizen watchdog organizations can therefore only access beneficial ownership information with consent from the company or through a court order;¹¹⁴ thereby limiting citizen-led accountability efforts.

I. Every private company in the health sector should be encouraged to conduct regular due diligence of its operations to ensure the company or its staff are not engaging in illicit finance, while also looking out for potential acts of illicit finance by third parties that it engages in business with. party to the agreements. The pharmaceutical industry, through its representative associations, has contradicting motivations. On the one hand, pharmaceutical manufacturers and distributors are motivated to support curbing of smuggling of drugs as this protects their market share. On the other hand, retailers are less inclined to fight smuggling as it provides them with cheaper drugs and helps them bring in new drugs for which they would prefer to avoid the costly and lengthy registration of new drugs. The pharmaceutical industry should ***commit to conducting ethical sourcing of drugs and building responsible supply chains.*** This could be done through joining the Pharmaceutical Supply Chain Initiative (PSCI)¹¹⁵ or a similar body, and abiding to its principles. Civil society can support the pharmaceuticals industry in conducting supply chain due diligence audits. CSOs and development partners can motivate ethical sourcing in the industry by only procuring from companies that abide by reputable ethical sourcing principles and has made appreciable progress in abiding

to the principles.

ii. These private companies should comply with the new Company's Act by submitting their beneficial ownership information to the Company's Registry by the 31st of December 2020. The Company's Act itself requires further strengthening to require the declaration of the true owner of shares owned by nominees or representatives¹¹⁶ where sometimes companies are not.

6.1.2. Recommendations for champions of reforms operating outside of the health sector

Key champions of reforms that operate outside of the health sector comprise of a range of non-state actors that include CSOs, political formations, some state actors and development partners. There exist opportunities for well-intentioned actors to make a difference in the quest to curb illicit finance in the short to medium term. Key recommendations for these champions of reform are outlined below.

Civil society organizations

Anti-corruption programming is a forte of CSOs that operate in what is known locally as the governance space – the swathe of CSOs and CBOs that implement programmes aimed at improving governance at various levels of society, and at times with certain niches in mind. Such CSOs cover some forms of illicit finance. Notably these CSOs cover types of illicit finance such as abuse of office and corrupt procurement where political leaders are involved. This typically leaves out types of illicit finance where lower level officials, citizens and the private sector are culprits – such as smuggling, trade misinvoicing and theft. There is therefore need for integrated anti-corruption programming in the health sector in which CSOs can potentially:

114. Section 73 (10) of the Companies and Other Business Entities Act

115. <https://pscinitiative.org/home>

116. "A nominee agreement is an arrangement between two parties where one person consents to acting as a director, secretary or shareholder for a company which is owned by someone else. The company is therefore left to assume the existence of such nominee arrangements and unless investigated, there is no obligation on shareholders to disclose these nominee arrangements or beneficial ownership" (Source: Macheka, A. 2020. Zimbabwe's New Companies Act [Chapter 24:31] of 2020. All You Need To Know)

i. Actively track and participate in the various steps of public health procurement at the national and local government levels. This tracking is key in raising red flags quickly and supporting efforts to hold public and private sector actors to account early, as a means to discourage and prevent corrupt procurement or at the least, raise awareness of corrupt procurement early. Tracking could be done with the use of a **publicly accessible online procurement contract tracker** that a broad group of CSOs, and potentially journalists, can use to compile available data on public procurement which ranges from adverts in the media and community-level noticeboards, minutes or notes from public processes such as the opening of bids or local government meetings and notices of awards. Civil society can take inspiration from the Budeshi initiative in Nigeria¹¹⁷ and the Prozorro platform in Ukraine¹¹⁸ and build on initiative's such as TI Z and ZIMCODD tracker s of COVID19 related procurement.

Box 12: Open Procurement Tracker

The procurement tracker could comprise of an online tabular database where each procurement contract's details are noted down. Key details to take note could include the name of the contractor, name of procuring entities, date of contract award, budgeted amount, value of contract and the status of implementation. The tracker could have advanced search functionality allowing users to conduct detailed searches and analyses. In addition, an interactive map could be used to show geographic distribution of contracts and make searches by location.

ii. Take advantage of GOZ's initiative to publish the entire National Budget in Program Based Budgeting format, whereby expenditure is linked to intended outputs and outcomes, by analysing achievements against targets. The analysis should be used in advocacy and shared with Parliament which can hold the Executive to account.

iii. Lobby for transparency of the beneficial ownership registry. As soon as the registry is fully constituted (12 months after the new Act became effective i.e. January 2021), civil society should identify a suitable case to seek a court order to disclose the beneficial owner of a specific company or organization, in order to set a, legal precedence. The recent Freedom of Information Act should also be utilized in this quest for transparency. Civil society should also campaign for companies to voluntarily make their beneficial ownership information publicly available.

iv. Exert international pressure on foreign companies that are seen to be engaging in illicit finance, by partnering civil society in their home countries and leveraging on legislation in their home countries to hold them to account. For example, a GOZ Gazette released on 27 April 2020 has a list of approved suppliers of detergents, medical and surgical sundries. While all registered firms are local, only 11% are manufacturing locally and the rest are importing from foreign manufacturers.

v. Partner like-minded CSOs in Zambia, Botswana, Mozambique and South Africa to uncover smuggling routes, and better understand the drivers of smuggling in these countries. The

117. <https://www.budeshi.ng>
118. <https://prozorro.gov.ua/en>

knowledge can then be used as a basis for advocacy. For example, CSOs in Zambia's governance space could conduct an APEA study of illicit finance in Zambia's health sector which could be used in conjunction with this study to provide evidence for lobbying for improved regional collaboration in combating illicit finance.

vi. Mobilize citizens to demand accountability from state actors for their actions and decisions and actively engage in platforms that exist for engagement between state bodies and the public.

vii. Develop the capacity of the Zimbabwe Anti-Corruption Commission (ZACC) with the techniques to investigate illicit financing including the techniques used in this study. Civil society can provide in-person training of ZACC personnel (and the media) and produce toolkits that provide knowledge and skills on the techniques.

Investigative journalists

Journalists and media houses have the unique opportunity to generate public interest on illicit finance. The media is polarized and the non-state media is quite compromised by vested interests which include some senior public officials and politicians involved in illicit finance. As revealed by a representative of journalists, this leads to coverage of illicit finance in the media which is motivated by factional politics and based on 'controlled leaks' of information from within GOZ. In order for the media to play its role as a 'watchdog' to protect public interest against malpractice and create public awareness by providing reliable information on illicit finance, it is recommended that:

i. The capacity of investigative journalists be strengthened so as to improve the quality and quantity of coverage of incidences of illicit finance.

The scan of media articles during the study's secondary literature shows that the majority of the media coverage of illicit finance do not sufficiently cover the drivers of the illicit activity, the systemic processes through which it was carried out and in-depth analysis of impact of the illicit activities. The Reuters Foundation has, with the Media Institute of Southern Africa (MISA), mentored journalists on reporting on illicit financial flows on a pilot basis. It is recommended that CSOs, Foundations, global media houses and development agencies continually develop the capacity of investigative journalists.

Development partners and agencies

International development agencies, which already have existing relationships with GOZ through which they help develop GOZ's capacity are encouraged to:

i. Develop the capacity of GOZ officials who engage in negotiations with the private sector for PPPs. Specific capacities that could be developed include development of contracts; monitoring and evaluation (M&E) and risk management; valuation of fixed assets; calculation of the cost of capital and project financial evaluation.¹¹⁹

ii. Support PRAZ in setting up an e-procurement platform with the legally required transparency. Development partners are encouraged to support GOZ in establishing such a platform.

119. The World Bank & DFID. 2009. Good Governance In Public-Private Partnerships: A Resource Guide for Practitioners

Parliament of Zimbabwe:

I. Play a role in ensuring GOZ meets the Abuja target by withholding approval of the National Budget unless the target is met, or appreciable progress towards meeting it is made. Further, Parliament should ensure the Executive actually makes the disbursements stated in the National Budget by questioning the Minister of Finance over any significant variances from the Budgeted amount when the Minister presents the consolidated financial statements to Parliament.

ii. Hold PRAZ to account by ensuring PRAZ publishes public procurement notices and notices of contract awards on the PRAZ website within 30 days of the contract award, as required by Section 68 of the PPDPA Act. Parliament can also follow up with PRAZ on its recommendation that PRAZ only register reputable companies and only engage reputable pre-registered suppliers for single-source public procurement contracts, unless they are unable to provide the supplies.

Office of the Auditor-General

The OAG which has proven to be a consistent champion for curbing illicit finance is encouraged to conduct forensic audits on theft of medical supplies from the public health sector, and the complicity of state institutions and officials in smuggling of medical supplies into the country.



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